Version 4.0

THE UNITED STATES GLOBAL HEALTH INITIATIVE

MOZAMBIQUE STRATEGY

2011-2015

I. Rationale and Vision for the Global Health Initiative in Mozambique

Vision- In direct response to the central problems facing the health sector in Mozambique – lack of access to basic services, difficulty in getting resources to where they are needed, and challenges in deploying and keeping trained health workers at all levels – the vision of the Global Health Initiative (GHI) strategy is to further collaborate with the Government of the Republic of Mozambique (GRM) and other local partners to reduce maternal, newborn, and child (MNC) mortality in rural populations. In this vision, GHI Mozambique will contribute to the ambitious GRM goals and the overall GHI goals of reduction in maternal, newborn, and child MNC mortality by 2015. Utilization of quality health care services will be improved by increasing access to high-impact evidence-based integrated maternal, newborn, and child health (MNCH) services, improving specific health-seeking behaviors, and improving specific components of the health system that will have the greatest impact on reducing mortality.

Reduction of MNC mortality is a top priority of the GRM and we believe the extraordinary reach of USG-supported programs across Mozambique, as well as our close engagement with the Ministry of Health (MOH), non-governmental organizations (NGOs), and the private sector, provides a unique and promising opportunity to effectively reduce MNC mortality in a manner that is fully country-owned and sustainable. The USG health team is convinced that it can successfully apply a "whole of government" approach in this area. To realize this vision, the USG will build on the robust programs that we are currently supporting, recognizing that they represent a key area of opportunity where implementation of the GHI principles can maximize USG impact. Improved effectiveness and efficiencies will be achieved through:

- Reorienting existing programs and developing new partnerships to ensure that we have no missed opportunities to reach more Mozambicans, particularly women and girls, with services that address their most basic health needs
- Continuing our focus on joint planning with local health authorities and accelerating our development of direct partnerships with local government and civil society entities
- Ensuring that our work at the central level to improve financial, human resource, and supply chain management is focused on getting needed resources to the local level
- Rolling out the GRM integrated package of MNCH services in communities where we are working;
- Improving monitoring and evaluation (M&E)

Implementation of the strategy outlined in the following pages will bring significant added value to the broad range of USG health initiatives already active in Mozambique and place increased emphasis on low-cost mechanisms to increase our impact.

II. GHI Mozambique Context and Priorities

Overview –Mozambique is a rural country with a current Human Development Index ranking of 165, out of 169 countries. Among the population of about 22million people, 55% live on less than one dollar per day. Health infrastructure is limited, with more than half of Mozambicans walking over one hour to reach the nearest health facility. Health facilities face frequent commodity stock outs and a general lack of basic amenities: 55% without electricity (MOH, 2009) and 41% without running water (MOH, 2010). Likewise, human resources for health (HRH) are severely constrained in Mozambique, with only 3 doctors and 21 nurses per 100,000 population (WHO, 2003) – a proportion that is among the lowest in the world. Systems for tracking, motivating, and retaining staff are weak. Frontline health providers are often poorly trained and have limited management skills, and

GRM capability to oversee its policies and regulations and to coordinate all health players is weak, resulting in poor supervision and coordination. Information systems and monitoring and evaluation (M&E) efforts are generally unable to provide timely and accurate health system data. Only 8%[1] of the national budget is allocated to health spending, and external resources or donor support accounted for 70% of state budget for health in 2010 (MOH Department of Planning and Cooperation, 2010).

The USG is Mozambique's largest bilateral donor, with the President's Emergency Plan for AIDS Relief (PEPFAR) – including special sub-initiatives such as the Gender Based Violence (GBV) Initiative, the Medical Education Partnership Initiative (MEPI), the Nursing Education Partnership Initiative (NEPI), the President's Malaria Initiative (PMI), the Millennium Challenge Corporation (MCC), and the Feed the Future Initiative (FTF). Under GHI, the USG is the leading donor in the Mozambican health sector (FY 2010 $340 million)through the Department of Defense (DOD),Department of Health and Human Services (Centers for Disease Control and Prevention [CDC]), National Institutes of Health [NIH], and Health Resources and Services Administration [HRSA]), Department of State (DOS), Peace Corps (PC), and the United States Agency for International Development (USAID).The USG also leverages Public-Private Partnerships (Coca Cola, Standard Bank, Vale).

Mozambique Priorities –GRM and MOH leadership has been actively confronting challenges in the health sector with varying levels of success. Current strengths include a comprehensive national vision with clear objectives stated in the Action Plan for the Reduction of Poverty, the 2007-2012 Mozambique National Health Plan (NHP) which has now been extended to 2012, and the Economic and Social Plan. Through these plans, the GRM has articulated a national health policy focused on strengthening primary health care, improving infrastructure, and increasing community-level engagement. The NHP mission is to improve the health status of the Mozambican population, focusing on vulnerable groups and especially women and children, by developing the pillars of Health Systems Strengthening (HSS) and integration, quality, and expansion of access to health care services. In 2009, the MOH also developed a strategy to include gender equality in the health sector. Overall health sector monitoring uses approximately 100 defined indicators and the NH incorporates existing disease- and population-specific plans, complemented by a costed National Plan for Development of Human Resources for Health (2008-2015) and a National Strategic Plan for Health Information Systems 2009-2014, among others. Mozambique is in the process of finalizing a national pharmaceutical logistics master plan by the end of 2011. NHP priorities with key indicators and main targets are shown in Table 1.

Strategy Alignment–The priorities of the Mozambique NHP and the USG GHI Program are well aligned, as demonstrated in Table 1. Furthermore, existing GRM activities support GHI goals and implementing principles, including emphasis on health system strengthening (HSS) and integration. In the area of HIV, some key examples include integrated positive prevention activities with HIV counseling and testing, care and treatment, and prevention of mother-to-child transmission (PMTCT) services. For malaria, mass distribution of insecticide-treated nets (ITNs), and indoor residual spraying (IRS) campaigns remain the main focus for prevention along with preventive treatment of pregnant women. Key family planning activities are based on integration into existing health

[1] GRM budget execution report, 2011

services and at the community level, as well as, a call for a plan of action to promote human rights and gender equity in regard to sexual and reproductive health. MNCH activities are an ideal candidate for the intersection of GRM and GHI priorities, particularly with a new Integrated Package of Services (IPS) developed by the MOH with USG support (see Appendix 4). The interventions/services are organized in four packages: 1) a community package that includes health education message about antenatal care visits, education communities to be able to recognize the early warning signs of complicated pregnancies for immediate referrals to appropriate hospitals, and malaria case management, 2) a minimal package at first-level health centers that adds for example prevention of mother-to-child transmission services, provides family planning and vaccinations, and referral for complicated malaria and labor, 3) a comprehensive package for the first referral level (second level of health centers) that adds management and treatment of mild to moderate complications due to malaria and during second and third stage of labor and provide post-abortion care, and 4) a specialized package for the third and fourth level health centers that includes management of prematurity and severe partum related trauma, treatment and care of severe cases of HIV, and intensive neonatal care. The USG will focus on supporting the implementation of the community and minimal packages.

Geographic Focus – For maximum impact, this strategy will intensify key interventions and activities in three provinces of Mozambique: Gaza, Sofala and Zambezia. Recognizing that a geographic focus will allow for demonstration of impact and better coordination and consolidation of existing platforms and programs supported by the various USG health programs, criteria were applied to select focus provinces for this initiative (see Box 1).

Box 1: Selection Criteria for Geographic Focus

1. Demonstrated MNCH and HIV need
2. High disease burden (rate and population density)
3. Poor health infrastructure and few human resources
4. Provincial capacity to respond
5. Existing USG platforms and potential for synergy (PEPFAR, GBV, FTF, PMI, other health, other donors)
6. Ability to demonstrate impact

Country-led Approach – The GRM has a well-developed donor coordination system that encourages country ownership and enables the USG to invest in country-led plans. USG Mozambique is already transitioning programs to align with the GRM strategic health priorities, strengthen GRM capacity to improve health outcomes, aid effectiveness and sustainability, and to increase civic participation at the community level. In addition, USG Mozambique has developed provincial coordination teams that harmonize USG support throughout the country, and has also renewed focus on building capacity of Mozambican team members to take on greater leadership roles, including transition of skills from U.S. direct hires to local personnel ("Mozambicanization"). The USG participates in Mozambique's Health Donor Group, as well as the MOH's MCH technical working group and Gender Group, which further enables us to leverage the efforts of other donors in keeping with GHI principles. USG Mozambique is already integrating foreign assistance planning into the GRM planning cycle, in collaboration with other development partners to leverage donor resources, and providing technical assistance to the MOH to strengthen performance and management of Global Fund resources.

Key Challenges –While the GRM and MOH have made great strides with USG support to develop a coherent national approach, and while there is encouraging overlap between GRM and GHI priorities and goals, the information in Table 1 reflects the magnitude of challenges still facing the health sector in Mozambique. Despite impressive achievements over the past 20 years, with some exceptions, Mozambique is not on track to achieve targets related to its own national goals, Millennium Development Goals (MDG), or GHI goals. MNC mortality is impacted by the concurrent HIV epidemic; high rates of malaria, tuberculosis and other infectious diseases; poor potable water and food insecurity; and lack of access to quality primary health care services. Mozambique's challenges to reducing MNC mortality, in the context of overall health system challenges outlined above, include human resources, financial management, and commodity supply chain. Mozambique's NHP highlights these areas as critical barriers to address, while civil society organizations, the health and development community and other donors reinforce the call for accelerated action to save the lives of vulnerable women and children.

USG Comparative Advantage – These critical barriers present a key opportunity for strengthening and scaling up, and the USG is currently supporting extensive systems and service delivery platforms that can be leveraged. The USG has emphasized support for developing HRH in recent planning cycles, including clinical skills building, task-shifting support, and HRH links to community focus such as re-vitalization of a community health worker (CHW) cadre. We are already supporting the MOH to strengthen its supply chain and commodity security in order for the GRM to achieve its desired objectives (especially important since access to medicines in Mozambique has declined significantly over the past several years). We have: 1) highly capable implementing partners in the three focus provinces of Mozambique covering both facility- and community-oriented interventions; 2) direct relationships with the MOH; 3) direct relationships with provincial MOH directorates; and 4) integrated programming across funding streams and agencies.

Table 1: PROGRESS IN ACHIEVING PRIORITY HEALTH TARGETS IN MOZAMBIQUE[2]

USG GHI Global Targets (established in 2010)	MDG Global Targets(established in 2000)	MZ Baseline	MZ Recent Results	MZ Targets/MDGs	Mozambique Progress Summary
Reduce under-five mortality rates by 35%	**Reduce by 2015 under five mortality rates by 66%**[3] **(MDG4)**	178 per 1000 live births (DHS, 2003)	157 per 1000 live births (MICS, 2008)	108 per 1000 live births (2015)	Under-5 mortality down but not on track to meet MDG 4
Halve the burden of Malaria[4]**for450 million people**	**Reduce mortality due to Malaria by 50%**	55 per 10,000(MOH, 2001)	N/A	33.6 per 10,000 (2014)	Progressing toward ambitious targets
Reduce maternal mortality by 30%	**Reduce maternal mortality rates by 75% (MDG5)**	408 per 100,000 (DHS, 2003)	478[2] per 100,000 (2008 modeled estimate)	250 per 100,000 live births (2015)	No clear downward trend; few data points available and differing methodologies complicate trend analysis
Prevent 54 million unintended pregnancies	**Increase Modern Contraceptive Prevalence (CPR)**	18.2 (DHS, 2003)	16.2% (MICS, 2008)	34% (2015)	Not on target
Prevent 12 million new HIV infections; Treat 4 million; Care for 12 million[5]	**Reduce HIV prevalence among pregnant women 15-24 by 25%**	11.3% (ANC surveillance, 2007)	12% (ANC surveillance, 2009)	8.5 % (2014)	HIV infection in pregnant women not on track to meet 2014 target
Contribute to a 50% reduction in TB burden and mortality burden	**Reduce prevalence of Tuberculosis by 50%**	636 per 100,000 (MOH, 2006)	504 per 100,000 (MOH, 2009)	144 per 100,000 (2015)	Improving and if continued acceleration could be on track to meet target

[2]GRM health sector works from M&E Matrix (MOH QAD Saude, 2008-2012). Most recent complete update is for 2010 data. Matrix includes baseline results, usually from the 2003 DHS; interim results for 2008-9 as available; interim annual targets; 2012 targets; 2010 results as available.
[3]For more information on the U.S. contribution to Mozambique's efforts to reduce maternal, neonatal and child mortality and to support universal access to sexual and reproductive health, see the BEST Action Plan for Mozambique (insert link once public).
[4]For more information on the U.S. contribution to Mozambique's efforts to address malaria burden, see the Malaria Operational Plan for Mozambique (http://www.fightingmalaria.gov/countries/mops/)
[5] For more information on the U.S. contribution to reduce incidence of HIV infection in youth and increase access to HIV/AIDS prevention, care and treatment, see the GRM/U.S. PEPFAR Partnership Framework (http://www.pepfar.gov/frameworks/mozambique/index.htm).

GHI Objectives, Program Structure, and Implementation

The United States Mission in Mozambique used specific criteria to select a focus on particular GHI health impact and outcomes with corresponding focal areas, major results, and activities(see Box 2).These choices were made in broad consultation with the USG interagency Health, Democracy and Governance, and Education sectors, the GRM, and civil society, and respond to the state of the health sector in Mozambique, reflect the priorities of the GRM and civil society, build on the strengths of the existing USG Mozambique health portfolio, and can bring additional value to Mozambique's health sector.

Under the GHI, the USG will work to **reduce MNC mortality in rural populations** through the following focal areas:

1. Strengthened governance in the health sector
2. Improved retention and management of the health workforce
3. Expanded access and uptake of quality MNCH services

Box 2: Selection Criteria for GHI Strategy Areas

1. Reflects and contributes to GRM national strategy and priorities
2. Is based on evidence to address Mozambican health needs
3. Affords opportunities for increased coordination, efficiencies, and impact
4. Builds on past successful USG collaborative efforts and best practices
5. Has strong GRM support and potential for increased country leadership and accountability
6. Improves sustainability

The expectation is that these focal areas will either reinforce or reorient existing USG investments in Mozambique within Gaza, Sofala and Zambezia provinces with the aim to accelerate and sustain results, as detailed in the GHI Mozambique Focus Area Results Framework (see Appendix 2).

FOCAL AREA ONE: STRENGTHENED GOVERNANCE IN THE PUBLIC HEALTH SECTOR

Significant governance issues affect the functioning of Mozambique's public health sector, including chronic underfunding, lack of accountability and transparency, and lack of management skills at all levels. USG Mozambique's work with the GRM at the central level will continue in critical areas (e.g., commodity management), while the focus of GHI in this area will be to identify and address key opportunities for innovative approaches that will directly contribute to achievement of GHI Mozambique goals, such as: local-level governance and engagement of civil society. Historically the Mozambican public sector, including health, has been highly centralized with limited mandates for sub-national administration levels to adequately address needs of the local population. Within the public health sector, critical health needs are often prioritized in strategic plans but not addressed through effective implementation and management to reach local levels. As a result, commodity stock-outs are frequent and widespread; human resources are not strategically deployed; funding does not reliably reach district and facility levels; and health service access issues limit coverage and uptake of key health interventions. The GRM's plan for decentralization has not yet been translated into the policies, laws, and implementation required to achieve local impact.

As the largest bilateral donor in the health sector, the USG recognizes its influence on the health system and contribution to overall health achievements. The United States has a strong comparative advantage in this focus area as a result of the significant presence of U.S. implementing partners at local levels. We believe that intensified efforts to support health sector decentralized planning and budgeting, public financial and commodity management and civil society engagement in decision making processes will have a significant impact on MCH mortality in Mozambique. Activities in this focus area will support both central level components necessary for successful implementation of decentralized system at the lowest levels and intensified local level support in the three focus provinces.

Major result: Improved planning, management, and execution at local levels

While we will continue to support coordinated and complementary central, provincial, and district level plans and priority allocation of USG investments at all levels under GHI, the USG will increase its support to decentralized planning, management and execution to ensure health priorities and resources at local levels respond to local needs, and contribute to greater transparency and accountability in the planning and budgeting process. Under GHI, existing USG provincial coordination teams will ensure that activities in each of the three focus provinces effectively rationalize and align all USG investments, through implementing partners and direct financing to the GRM, with provincial priorities and planning and are captured in GRM planning processes and documentation. The USG Gender advisor works closely with the USG provincial teams to ensure that gender issues are addressed during sites visits and that the GRM provincial gender focal point is included in the discussions when appropriate. Central to our effort to ensure the flow of budget funds to local levels, the USG will ensure better decentralized tracking of funds allocated to provincial and district levels through strengthening of a routine system (through standardized quarterly reports) to monitor USG health expenditures. Moreover, we will aim to capture all our investments in GRM planning processes and documentation by 2015.

Current GRM financial management is sufficiently weak such that both Global Fund and USG direct funding have been intermittently suspended for audits and improved documentation before funds can resume. Even when allocations are planned appropriately, provincial and district level governments do not necessarily receive the funds intended due to poor budget execution. The USG is committed to an approach that builds GRM financial management capacity to allow for direct financing to the GRM at central and local levels.

Major result: Improved commodities management to ensure availability at local levels

The USG is expanding its current work with the GRM's central commodities management unit to incorporate a decentralized approach to supporting the commodity and logistics system that will ensure key commodities are provided to local facilities and communities where they are needed. This may include involvement of USG clinical and community partners, which are critically placed to work with national level technical assistance providers to assist and capacitate health workers at lower levels of the system to adequately plan and manage commodities. Under GHI new emphasis on improved logistics at the local level will include necessary infrastructure development, functional post-marketing surveillance, and renewed focus on forecasting and quantification based on accurate and current

information. A balance of mixed investments at both the central and local levels in the three focus provinces will be required to ensure a strong supply chain delivery system to reduce MCH mortality in rural populations.

Major result: Increased GRM investment in the health and social welfare sectors

The USG can further strengthen governance in the Mozambican health sector by shifting the focus away from building financial management of implementing partners to building host government financial management capacity at national and provincial levels. Under GHI, the USG aims to increase its use of government systems as a way of building a strong and sustainable health system. Currently, the national health budget excludes all USG bilateral health investments (which are twice that of GRM national health budget investments) and only a small number of USG health investments go directly to the GRM, and none through GRM financial management systems. The USG will intensify its financial capacity building of provincial and district health teams through both the USG provincial health teams and USG implementing partners so that they are better able to execute and track resources in a transparent and accountable manner.

While the aforementioned interventions are critical to improving the retention and turnover of health workers, they will not produce measureable results if there are insufficient funds in the overall national health budget to pay salaries of health care workers. Despite committing to increase health sector budget to 15% of national budget as a signatory to the Abuja Declaration, the percentage of GRM funds to the health sector has declined from 14% in 2006 to 8% of the state budget in 2010[6]. The USG commits to intensifying advocacy with the GRM at the highest levels to ensure it is investing in its own health sector appropriately so that USG efforts are part of a sustainable plan for strengthening the public health sector. This investment is a critical benchmark of the PEPFAR Partnership Framework and good governance by the GRM, and aligns well with the USG prioritization of democracy and governance in the Country Assistance Strategy and the Mission Strategic Resource Plan. As part of the GHI and the PEPFAR Partnership Framework, the USG is monitoring this commitment annually with the GRM and other bilateral and multilateral donors.

Major result: Improved civil society engagement in the health sector

Although the GRM is promoting public sector reform to improve the quality of service delivery across government, scant attention has been paid to improving citizen demand for better and more accountable services and engaging them in the decentralization process. A recent baseline study[7]found that significant percentages of people had difficulty accessing health and education services, and found large regional variations. Citizen engagement with government through collective action (throughout the service delivery and local planning processes) can result in improved access to and quality of services and increased demand from citizens. This engagement, which is weak in Mozambique, needs to have a

[6]Although the G-19 Economic Working Group shows the actual amount (not % of total) has risen annually for the past few years.
[7]United Kingdom's Department for International Development (DFID) , 2010

strong focus on empowering citizens. In order to strengthen citizen engagement in health sector planning and service delivery, the USG will increase the capacity of civil society organizations and advocacy networks to inform GRM planning and increase transparency and accountability. USG investments in civil society organizations have mainly been limited to funding implementation activities of specific initiatives rather than building their capacity to influence policy, participate in planning processes, and hold government to account. The USG will identify financing mechanisms to support national and community civil society organizations and networks to participate in decision-making processes and increase their capacity to advocate and influence. Mechanisms will be developed to receive proposals for advocacy initiatives that USG can fund directly. Existing programs will add a new emphasis on advocacy capacity and the role of networks in representing their constituencies and articulating an advocacy agenda. To better coordinate and maximize investments in this area, the USG will develop a Health and Civil Society Engagement Strategy for Mozambique. The strategy will leverage all USG investments and partners, including those supported by health, democracy and governance; complement the work of other donors, and highlight the three focus provinces.

Concrete examples of proposed support to civil society as advocates:

- Through existing programs, support will be provided to civil society networks in accessing and sharing key information, such as budgets, national plans, and laws. Support to analyse and monitor budgets and policies, and develop and implement advocacy plans will also be provided.
- The USG will leverage and support the role of networks and umbrella organizations for women's groups to address cultural and gender barriers to participation in health sector planning and service delivery as well as to monitor health and social services. Networks and umbrella organizations will be identified for direct funding to support their roles as coordinators and advocates, rather than asking them to implement projects.
- Through the GBV Initiative, support will be provided to build CSOs' capacity to monitor, prevent, and address GBV in their communities, involving men, women and key decision-makers.
- Linkages will be created to USAID's Democracy and Governance program, which will include strengthening media capacity to inform citizens and building CSO capacity to represent citizen's health priorities. Health and DG teams will work together to train journalists and civil society on governance issues in the health sector and the roles and responsibilities of rights-claimers and duty-bearers.

FOCAL AREA 2: IMPROVED RETENTION AND MANAGEMENT OF THE HEALTH WORKFORCE

Mozambique has a critical human resource gap at all levels that is a key obstacle to sustainable progress toward GHI goals. Currently, Mozambique produces 2000 health workforce graduates a year but can only absorb 1000 into government posts[8]. A skilled workforce that is managed well within the system (posted to relevant areas using deployment practices and procedures and retained in posts, especially rural areas), and is motivated, productive and results-oriented will have significantly greater impact on

[8]The Ministry of Health's Human Resources Directorate Annual Report, 2010

MNCH results in the country. More workers staying in the public sector and more workers available in rural areas should yield better access and uptake of MNCH services. Critical challenges include 1) proportionally diminishing public funding to the health sector for health worker salaries, 2) inadequate systems for tracking and retaining staff, 3) non-strategic deployment and placement of health care workers, and 4) low absorption of recently graduated health care workers into the government system. Pre-service and in-service clinical skills training remains weak and, due to the lack of personnel with specific training in administration, human resource management, and supply chain systems, deployed clinical staff struggle to perform these additional duties. Retention has become a focus of the MOH as it implements the updated HRH plan with a goal to improve the performance of the National Health Service (NHS) through a better distributed, retained, and motivated workforce.

Currently, USG investments in human resources for health (HRH) focus on in-service skill updates and pre-service education, such as curriculum development and scholarships for clinical staff, with the primary goal of increasing the number of health care workers (HCW) and improving the quality of pre-service education. As part of the Gender-based Violence Initiative, the nursing pre-service curriculum includes a GBV module; other cadres' curricula will follow. Under GHI, the USG HRH portfolio will increase attention on recruitment, deployment, and retention for essential health worker cadres critical to reaching rural populations, as well as training and deploying non-clinical cadres such as health administrators, managers, and supply chain logisticians. This new approach will complement continued support for training activities that help ensure skilled HCWs remain in the public health system, benefit from appropriate supervision and management, and are empowered to provide high quality MNCH services. Efforts to ensure gender parity in the public health force will be critical along with efforts to promote equal opportunities for both men and women. This shift complements decentralization efforts by strengthening host government human resource management and other priority cadres to support effective planning for resources at local levels. A balance of mixed investments at both the central and local levels in the three focus provinces will be required to ensure Mozambique has a skilled, well distributed public health workforce to reduce MCH mortality in rural populations.

Major result: Improved capacity to better distribute and retain skilled workers

The USG will support implementation of data systems for decision making—such as a Human Resource Information System (HRIS) implemented down to the district level —that will be critical for supporting health workforce planning, deployment, management, continuing education, and career advancement, and will include a five-year M&E strategy to monitor its implementation. Through investments in the HRIS, and its decentralization use at local levels, the USG will help the GRM revise and update procedures for recruitment, allocation, and deployment. The USG will explore opportunities to move national public health care workers who are currently funded by the USG through implementing partners into the GRM payroll system to ensure all health care workers are captured in the HRIS for tracking and planning purposes. Under GHI the USG will continue to support re-vitalization and expansion of the GRM's CHW cadre.

Major result: Improved motivation, performance, and productivity

The GRM recognizes the need for a HRH retention strategy that focuses efforts on incentives that retain and sustain quality health workers. Under GHI, the USG will support GRM efforts to develop and implement this strategy with a focus on rural retention. In addition, the USG will build on current experimentation with performance-based financing and will further develop quality assurance and quality improvement activities based on current approaches. Performance-based financing (PBF) is predicated upon the notion that funding should be focused on outcomes. Acknowledging that inputs are necessary but not sufficient to strengthen the health system and enable healthcare providers and health facilities to maximally serve the population, the USG team in Mozambique is currently exploring a hybrid approach that combines input with output-based financing. Linking funding to performance, as measured by the key outcome variables that the GHI strategy is seeking to impact (i.e.: facility-based deliveries, vaccination completion rates, etc.) offers a promising and innovative alternative to traditional input-based financing. Addressing health-care worker incentives is an important complement to resources, technical, and capacity building inputs that current USG implementing partners are providing. A growing body of evidence suggests that performance-based incentives (PBIs) may be part of the solution. Under the GHI, we plan to expand pilot programs to four provinces through clinical partners and complement partner result-based district and provincial sub-agreements with direct USG funded sub-agreements through host country funding mechanisms. Plans are in place to provide results-based direct financing to the central medical stores and possibly other areas of the Ministry of Health. We also will work with other donors on demand-based financing to determine possible scale-up in our community-based service delivery programs, first and foremost with the CHW and other community-based cadres delivering and monitoring mother and child health at local levels. Complementary to the Governance Focus Area, the USG team hypothesizes that financial risk drives change and that results-based payments may change the workforce capacity within the system, the way staff govern, and how planning, management, and execution happen at local levels, including commodities management. We believe that delivering funding differently and tracking performance will impact how local capacity-building happens and how local systems are strengthened.

In addition to PBF, the USG is also committed to implementing demand-side initiatives that specifically target the root causes of poverty for populations traditionally underserved by the health system. Partnering with the United Kingdom's Department for International Development (DFID) demand-based financing program, the USG will explore demand-side financing opportunities focused on decreasing maternal and child mortality.

Under the GHI, we will also support assessments to determine what areas of investment will lead to strengthened management of performance, career progression, and promotion of cadres. Several planned studies will augment our capacity to understand what motivates health workers at various levels. USG GHI investments will also help develop updated salary scales and levels for HRH. Provincial and district-based USG implementing partners will support the GRM to improve working conditions of health workers at the site level.

Major result: Improved capacity to manage, plan, and administer the health service delivery system

To improve country-led plans and sustainability of USG investments in Mozambique, the USG team will place more emphasis on a system managed by health management specialists. Specifically, the USG will focus efforts on developing health management and administration cadres such as hospital administrators, supply chain managers, provincial and district administrators, key MOH program and department directors, and even monitoring and evaluation staff. As these cadres are not well defined in Mozambique, the USG will identify specific ways to train and empower these health care managers and administrators. Under GHI, the USG will support the MOH to revise and update specific criteria for health cadres, including financial management cadres, hospital administrators, and supply chain logisticians. For example, the USG is exploring options to support a superior-level health management course that started recently at the National Health Sciences Institute. Support may include curriculum improvements, faculty development, updated materials, research activities, and ensuring the course is aligned to health sector management needs. This course is complementary to efforts by other donors in this same area.

FOCUS AREA THREE: EXPANDED ACCESS AND UPTAKE OF QUALITY MNCH SERVICES

In Mozambique, MNC mortality is impacted by high rates of malaria, tuberculosis, and other infectious diseases; the concurrent HIV epidemic; water and food insecurity; lack of access to quality primary health care services; lack of community utilization of available services; and weak M&E systems that impede management and quality assurance efforts. In response, the GRM, with USG support, outlined the Integrated Package of Services (IPS) to address community health needs. The IPS is designed to improve uptake of high-impact, evidence-based interventions based on the major causes of MNC mortality. The MOH has finalized the integrated package and is now in the early stages of rolling out implementation throughout the country at all levels of service delivery. Historically, mandates of USG partners were limited to addressing specific diseases or conditions with limited flexibility to support an integrated health approach. Under GHI, USG implementing partner support previously developed through existing investments (in particular PEPFAR), will be leveraged to support a broader integrated approach for improved MNCH outcomes. In alignment with the principle of country ownership, the USG will redirect current implementing partners and programs, regardless of funding stream, to more holistically support and build MOH capacity to implement the IPS. Specifically, the USG will accelerate implementation of the community and minimal packages of the IPS in primary health facilities and communities supported by current USG partners and will identify new opportunities to build the capacity of local government and civil society to improve the linkages between communities and primary health facilities. (See Box 3)

Box 3

Community Package			
Service Delivery Point	***Service Providers***	***Interventions to continue and intensify***	***New focus***

Communities and Health Posts	Community Health Workers (CHW)CHWs, Elementary Nurses and Midwifes	- Information, education, communication (IEC) for pregnancy, malaria, Water and sanitation and hygiene (WASH), nutrition - Routine immunizations - Nutritional assessment (e.g. mid-upper arm circumference (MUAC) - Malaria case management - Distribution of cotrimoxazole - Family planning	Reach Every District (R.E.D)
Minimal Package			
Service Delivery Point	**Service Providers**	**Interventions to continue and intensify**	**New focus**
Health Posts and Type II Rural Health Centers	Elementary Nurses, Midwifes and Nutrition agents	- Malaria in pregnancy (MIP) - ANC/PMTCT/Postnatal care - Family Planning	- Nutrition assessment and counseling support (NACS) - Active management of third stage of labor (AMTSL) - Referral systems for complicated malaria and labor

All the interventions outlined above in each of the packages will need direct indicators or proxy indicators identified as well as reliable data set resources to determine a baseline and ongoing measurements for demonstrating impact.

Major result: Increased availability of national "Integrated Package of Services" The USG team in Mozambique believes it can support expansion of the IPS at a relatively low incremental cost by leveraging training and supervision platforms built through past investments. For example, the USG is utilizing existing PEPFAR-supported clinical and community partners to increase availability and utilization of PMTCT services that are fully integrated into MNCH platforms. Based on the Lives Saved

Tool (LiST) analysis model, the USG estimates that expanding IPS into 75% of all MNCH facilities in Mozambique have the potential to save approximately 141,000 lives of mothers, newborn children, and children under 5 by 2015. In order to demonstrate the impact of expansion of the integrated package as part of this GHI strategy, the USG will enhance capacity for modeling lives saved specifically in the three focus provinces, tracking milestones for key activities, and strengthening M&E systems to allow for accurate outcomes measurement. As a critical first step, the USG will intensify its partnership with the MOH to strengthen its leadership and capacity to implement the IPS. Lack of capacity at the central level has delayed policy development and dissemination, slowed service delivery, and created significant delays in launching M&E systems linked to IPS rollout. The USG will work with the MOH to ensure that training and supervision tools for the IPS rollout reinforce ongoing work to establish a national quality improvement strategy. Training and capacity-building activities will leverage existing USG-supported training and capacity building partners at the national level, and will incorporate results of a USG-supported national PMTCT program review that is currently under development.

Achievement of the GHI goals in Mozambique will depend on continued efforts to bring quality health and social services closer to communities in order to increase uptake of health sector services. Under GHI, the USG will partner with the GRM and civil society to extend the reach of critical MNCH services to communities by sensitizing and mobilizing communities to take advantage of facility-based services, including labor and delivery; engaging men as supportive partners; supporting mobile brigades; and by supporting development of the CHW cadre. As details around implementation of USG support for the mobile brigades and CHW becomes available (e.g. more specific data on baselines and coverage details), a more detailed modeling analysis can be undertaken to understand how these enhanced investments in the three focus provinces will increase access to evidence-based, high-impact interventions with implications for reduced mortality and morbidity. (See Annex 4 for complete IPS description)

Major result: Increased utilization of national "Integrated Package of Services"

Expanding IPS availability and access as described above will have impact on health outcomes only if relevant health services are actually utilized by members of the community. While the approach under GHI will be to leverage extensive existing resources to improve quality and expand service reach into communities, there is also a critical need for increased community demand for services. Basic health promotion, demand side incentives, expansion of patient empowerment groups, identification of cultural and gender barriers related to utilization and other innovative approaches will be supported under GHI, building on local knowledge and capacity of existing USG-supported platforms. Improved collaboration with community-based health practitioners and community coordination groups will be pursued; and focusing on humanized health services will help support community interest in utilizing health services. In addition, a key emphasis will be on eliminating missed opportunities by ensuring that individuals who have contact with the health system are not lost to follow up. Specifically, linkages across health services and linkages between communities and health facilities will be strengthened to maximize retention of clients in MNCH services.

Major result: Increased involvement of communities in design, implementation, and evaluation of interventions

Community engagement for IPS will be pursued as a complementary activity with civil society strengthening as detailed above. Under GHI, a new emphasis on the role of communities in health sector planning and management will be developed – this includes making sure that women are engaged in local health committees and training the local health committees on data management and analysis – including analyzing data for gender differences. Educated and empowered community health councils will be able to provide meaningful advocacy and will be able to hold GRM health services accountable for community health outcomes.

SMART INTEGRATION

Throughout the GHI Mozambique strategy "integration" plays a key role on several levels, including integration of USG planning and processes across agencies to improve coordination and leverage resources; integration of USG planning with GRM planning in order to support country-led plans; and integration of specific health components into particular health packages that support availability and uptake of key evidence-based interventions to reduce MNC mortality. In each application, "integration" refers to "smart integration" as defined in GHI guidance.

A specific example of the USG's approach to smart integration in Mozambique includes our current interagency health portfolio review. The USG interagency health team recently conducted the first interagency review of the health portfolio. A critical need identified as part of this process is one USG results framework and monitoring plan which the team intends to create by October, 2011. Additionally, as part of the integrated and coordinated monitoring of partners, the USG aims to create standardized quarterly reports for all USG implementing partners which will track routine expenditures in a common way that will be reflected in one USG health quarterly report for all partners.

Another example is enhanced engagement with the GRM through USG Provincial Coordination Teams. The USG interagency health team established interagency provincial teams in 2010 as a vehicle to strengthen country ownership and to improve integration and coordination. The Provincial Teams aim to strengthen relationships with provincial government partners, better coordinate and monitor USG implementing partners, engage in direct funding agreements with provinces as appropriate, and undertake joint USG-GRM planning for maximum impact at the provincial and district levels.

WOMEN, GIRLS, AND GENDER EQUALITY

Reducing MNC mortality requires focusing not just on the well-being of women but of older adolescent girls as well. Mozambique has one of the highest proportions of early marriage in the world: 52% of women ages 20-24 are married by age 18[9]. This statistic, combined with the age of sexual debut at 16 years of age, is cause for alarm. One of the most vulnerable populations in Mozambique is the married, adolescent female. She is more than likely uneducated, isolated with limited social networks, has little

[9] UNICEF, www.childinfo.org/marriage_countrydata.php

sexual-decision making power, and, depending on where she lives, is most likely HIV positive. Efforts to reduce MNC mortality will provide an entry point to better serve this often hard-to-reach, vulnerable female and her family throughout USG programs.

Each year, the USG Gender Advisor produces and distributes a document on the status of women and girls in Mozambique that looks at recent data on women and girls' health, education, productivity and participation. This document serves as a resource for the entire USG program, including the GHI. A specific gender analysis may be needed to further obtain an in-depth understanding of the three focal areas working to reduce MNC mortality in rural populations, such as the barriers to women's entry and retention within the public health workforce or barriers to utilization of the IPS. The entire PEPFAR portfolio is scrutinized to guarantee that that the five PEPFAR gender focal areas are addressed through the portfolio; the same will be done under GHI for the WGGE principle within PEPFAR and other USG programs. The GBV Initiative is focusing in two of the three GHI provinces, Sofala and Gaza, and the USG education program is expected to focus on Zambezia province, with a focus on girls. The GHI will leverage these programs and integrate within planned activities to ensure maximum reach with limited resources and to address structural issues related to empowerment of women and girls.

USG staff has recently been trained on gender issues within the health sector and an interagency team coordinates efforts under the GBV Initiative. Gender issues are thus also addressed within the USG provincial teams. Further training on gender issues and M&E is planned within the next year for USG staff as well as partner staff to ensure that sex-disaggregated data is collected and analysed for gender differences to inform programming.

ACHIEVEMENT OF GHI TARGETS AND OBJECTIVES

Supporting the GHI approach in Mozambique is the hypothesis that significant reductions in MNCH mortality can be achieved in Mozambique through (1) decentralized planning and budgeting within the health sector that engages civil society in decision-making processes, (2) a fully-deployed, productive and supported health workforce that is empowered to address the needs of the population, and (3) access to and utilization of high-impact, evidence-based interventions to address the major causes of MNC mortality. By bringing the decision-making and accountability for health expenditures and resources closer to communities, we expect to see improvements in the quality of health care delivery in rural parts of Mozambique, and a significant and positive effect on the livelihoods of women, girls and children by improving demand for and utilization of life-saving health services.

Investments to improve governance of the public health sector and human resources in Mozambique are critical to achieving rapid reductions in mortality. Without these critical system investments the tremendous health and development progress made to date will not be sustained and further gains will not be realized. Though the World Bank cannot explain clearly how decentralization improves health outcomes, and experiential evidence from countries that have undergone decentralization in the health

sector is mixed,[10] rigorous evaluations are emerging that demonstrate dramatic results when communities—the beneficiaries of the health sector—are empowered to drive accountability for quality service delivery and contribute to health-sector decision-making.

For example, in Uganda, researchers conducted a randomized evaluation at 50 dispensaries from nine districts to see if community monitoring would improve health worker performance and the impact this might have on health utilization and outcomes.[11] In the intervention group, utilization of general outpatient services was higher (20%), more people came for child birth deliveries (58%), and more patients sought prenatal care (19%). More people sought family planning services (22%) and immunizations increased for all age groups, especially newborns. Households also began switching from self -treatment and traditional healers to dispensaries in response to the intervention. Relative to the comparison group, intervention communities saw an increase in infant weight and a 33% reduction in the mortality of children under 5 years old.

We are committed to moving forward with testing and evaluating the GHI approach in Mozambique in order to contribute to the global body of knowledge on what works to reduce MNC mortality and why.

Governance -USG experience in Mozambique suggests that one of the primary constraints to improved functioning of the public health system has been the low management capacity of officials in leadership positions at all levels. Providing direct financing through government systems forces us to build this management capacity and systems of incentives, oversight, and control required to ensure success. We also believe that a decentralized model of support using host-country finance systems that allows government teams to control their own budgets, planning processes, and management of programs will, in turn result in strong linkages between strategic planning and budgeting that will positively impact budget execution, the management of the health workforce, and availability of commodities. This will ultimately result in focusing resources on the priority needs of users at all levels of the system and improved health outcomes. The USG is committed to working with the GRM to improve its own monitoring and reporting system, rather than building parallel donor-created systems and organizations, to rigorously evaluate efforts to improve governance, and to monitor concrete improvements in key health system outputs, such as improved access to life-saving commodities at lower-level health facilities.

Since maternal, neonatal and child mortality rates are only reported every few years in Mozambique, we will rely on priority milestones and annual GRM indicators to measure and monitor progress in Mozambique. For example, we hypothesize that increasing the execution of USG direct provincial funding agreements by 2013 and aligning USG health partner work plans with provincial and district priorities (annual plans) by August 2012 will result in improved planning, management, and execution at local levels. These efforts, in turn, will result in an increase in the percentage of GRM audits completed without negative results as well as an increase in expenditures as a percentage of the approved health

[10] http://www1.worldbank.org/publicsector/decentralization/service.htm#2
[11] http://www.povertyactionlab.org/evaluation/community-based-monitoring-primary-healthcare-providers-uganda

sector budget. Ultimately this financial management and execution at local levels will result in reduced maternal, newborn, and child health in rural populations.

Although change in civil society capacity to influence policy is a long-term process, progress can be measured by more tangible benchmarks. We believe that an enhanced role for and capability of civil society to demand access to quality, as demonstrated by an increase in the number of districts in which civil society participates in health sector planning and monitoring processes, will result in an increase in access and uptake of MNCH services and ultimately reduce maternal, neonatal, and child mortality. See Appendix 2 for additional priority milestones and Appendix 3 for GRM outcomes anticipated as a result of these priority milestones. These benchmarks and indicators are proxies to reflect how well the health system is responding to the needs of the population and how efforts to strengthen the governance of the system are making a difference in the care Mozambicans receive.

To further understand how efforts to strengthen governance in Mozambique can lead to sustained health outcomes, the USG will support a GHI learning agenda with funding and technical support to better understand these linkages.

A focus on governance supports the GHI by 1) strengthening country ownership and accountability, 2) building sustainable health systems through support for the GRM decentralization strategy and a strategy to enhance engagement of civil society, and 3) building on the USG comparative advantage within the donor community and leveraging other bilateral and multilateral donor investments.

Human Resources for Health –Improved retention and management of human resources will be necessary to sustain health and development progress. A WHO-developed framework on the impact of HRH investments on maternal mortality[12]demonstrates that implementation of HRH management systems to improve the availability, training, education, and retention of doctors, nurses, midwives, and technicians contributes to improved maternal health. For example, increasing the availability of the human resources in the form of skilled health workers by training them to recognize and manage obstetric complications can decrease maternal mortality significantly. Still more work needs to be done in other areas of HRH interventions, especially recruitment, deployment and retention of the health care workers in rural areas, improvement in the work environment and conditions, and HRH information systems.

The USG is committed to working with the GRM to rigorously evaluate efforts to improve HRH deployment and management and to monitor concrete improvements in key health system outputs, such as improved rates of districts with a full complement of deployed heath care workers based on an HRH plan — a proxy to reflect how well the health system is positioned to respond to the needs of the population. We expect, for example, that conducting an assessment of existing information sources related to staff rotation practices and policies and piloting virtual consultations between rural health posts by June 2012 will allow us to identify concrete steps to increase the percentage of rural districts fully staffed based on their local HR plan, which will have an impact on maternal, child, and neonatal

[12]http://www.who.int/pmnch/activities/human_resources/hrh_maternal_health_2010.pdf

health in rural populations in Mozambique. See Appendix 2 for additional priority milestones and Appendix 3 for GRM outcomes anticipated as a result of these priority milestones.

This focus area aligns USG investments with several GHI principles by strengthening country ownership and health systems through support for revising GRM procedures for health workforce recruitment, allocation, deployment, and retention and by building on the USG comparative advantage within donor community to leverage other bilateral and multilateral donor investments such as the European Union (management, planning, and administration), World Bank (Performance Based Financing), and the Belgian Cooperation (human resources management).

National "Integrated Package of Services" – Aligning with the GRM to support IPS addresses both the demonstrated health needs of Mozambicans and supports achievement of GHI targets and outcomes. For example, through 1) development of a curriculum for health committee data management and analysis by December 2011, 2) revision and implementation of IPS-MNCH facility based registers and reporting forms to support government reporting and measure progress in delivering the IPS-MNCH by June 2012, and 3) piloted and evaluated novel strategies for rural referral and transportation by December 2012, the USG will contribute to significant positive results: an increase institutional deliveries and the proportion of children under five years old with fever in the last two weeks who received treatment with artemisinin-based combination therapies (ACTs) within 24 hours of onset of fever due to malaria. These results will ultimately reduce MNCH mortality in the rural population. See Appendix 2 for additional priority milestones and Appendix 3 for GRM outcomes anticipated as a result of these priority milestones.

This approach fundamentally addresses women and girls and is driven by their health needs in the Mozambican context. Further, this focus area aligns USG investments with several GHI principles by 1) utilizing existing USG investments to scale up an integrated package of high-impact interventions, 2) strengthening country ownership and health systems through support for the GRM's strategy to deploy the IPS-MNCH, with additional opportunities to strengthen the quality of service delivery through improved supervision and reporting systems, 3) leveraging the USG comparative advantage as a leading donor and partner in influencing and supporting the GRM's strategies for MCH, HIV/AIDS, health systems strengthening, and M&E especially at the provincial, district and site level, and 4) providing an opportunity to contribute to research and evaluation by answering potential questions related to integration, e.g. "Does the approach compromise quality of service in specific disease, condition, or program areas? What is the overall impact on health outcomes?"

PROCESSES AND MECHANISMS

The USG took an inclusive, "whole- of-country" approach to the development of the GHI strategy, with participation from interagency Health, Democracy and Governance, and Education sectors, the GRM, and civil society. Critical aspects to the success of the development process include an analysis of the USG health investments with the NHP, development of clear criteria for decision making (see Boxes 1 and 2), a critical review of missed opportunities across the USG health and development portfolios, and

engagement with the GRM and civil society representatives. Following a series of successful conversations with civil society on GHI, the USG has decided to strengthen its engagement and coordination with civil society, using existing regular meetings of the civil society platform to ensure they are involved in the design, implementation, and monitoring of programs that affect them.

In upholding the GHI principle of sustainability, the significant bilateral investments call for review of how we interface with the public health system to support country ownership (see Box 4), with the ultimate goal for the USG to increase not only its alignment but its use of host country systems as a way of building a better governed and sustainable health system. To ensure USG health programs are effectively aligned and coordinated with the priorities and efforts of Mozambique's national health strategies and monitoring frameworks, the USG will strive to include Mozambican leadership and communities in the development and selection phase of various types of funding opportunities and ensure the women, girls and gender equality principle is consistently applied.

To effectively implement the GHI, the USG will prioritize close harmonization and communication internally across its agencies and disciplines, as well as externally with the GRM and partners, both local and international; and will also use bilateral and multilateral coordination mechanisms with the GRM, civil society, and other donors. As part of the GHI, the USG team will strive to balance efficiency and inclusivity and undertake a review of current interagency structures and the GHI development process to distill lessons to inform the GHI implementation structure, with the overall aim of balancing the utilization of existing structures and creation of any new structures to ensure effective "whole- of-government" implementation and monitoring. The use of the recently established USG Provincial Teams described above will serve as a critical mechanism to further provide provinces with direct technical assistance in budgeting and planning, better coordinate partners working in the province, and ensure efficient and effective use of USG resources in support of Mozambican priorities. USG agencies working in Mozambique also committed to an interagency working agreement that promotes transparency and increases coordination across USG investments and will serve to guide operationalization of the GHI.

III. Monitoring and Evaluation and Learning

In supporting one national M&E system, USG implementing partners will continue to align with and support the GRM's national health indicators with intensified efforts to strengthen national M&E systems. Implemented IPS activities will be reported through GRM paper- and electronic-based systems. USG implementing partners in these activities will ensure that their M&E systems are directly aligned and strengthen national and provincial reporting as part of the national aggregated health database. Progress will be measured against benchmarks and national targets to demonstrate improvements in health outcomes regardless of funding source. This approach demonstrates a paradigm shift in reporting for the USG as it adapts systems appropriate for integrated services and their contributions to larger health outcomes, not simply vertical or disease service provision. Routine reporting of partner level data under Presidential Initiatives, currently well-aligned with GRM national indicators, will

continue to provide essential data for monitoring performance and to ensure compliance with procurement agreements. Overall evaluation of GHI impact will also benefit from the Demographic Health Survey scheduled this year.

Promote learning and accountability through monitoring and evaluation

- Support GRM development of five-year health sector wide M&E Plan, which will feed into annual planning and set standards for program and outcome monitoring
- Build capacity of GRM to collect, track, and evaluate gender-related indicators
- Align USG indicators and targets with the national M&E Plan, to greatest extent possible
- Strengthen, expand and coordinate data sources for service- and population- level data through joint technical and financial support
    - Support and expand Demographic Health Surveillance centers in Mozambique
    - Strengthen mortality surveillance systems and vital registration
- Develop USG-wide data quality assurance standards (to be used by USG and possibly other foreign assistance partners)
- Strengthen human resources in strategic information and M&E at all levels, including analytic capacity to use data for decision making

Accelerate results through research and innovation

Although Mozambique is not a GHI Plus country, the USG team in Mozambique is designing a Learning Agenda to define the approach to monitoring the impact of GHI strategy activities. The Learning Agenda will be prioritized for funding, drawing on resources across the various USG programs and agencies. In Mozambique, routine program data is of poor quality and population-based surveys have not occurred on schedule leading to a paucity of data for baseline analyses and assessment of progress toward overarching health outcomes. The USG will address this situation by investing in national systems to improve the quality of routine data while using targeted evaluations in the near term to provide critical data on the status of the health sector and progress toward the GHI targets. The Mozambican National Institute of Health (INS) has been proactive in the past year and will serve as a leader in developing the national research agenda which the USG will support. In addition, the USG will prioritize economic analyses including expenditures and program costing to provide concrete information for cost-effective scale up and will specifically address system strengthening efforts and identify ways to document these critical investments.

The GHI Learning Agenda for Mozambique will:

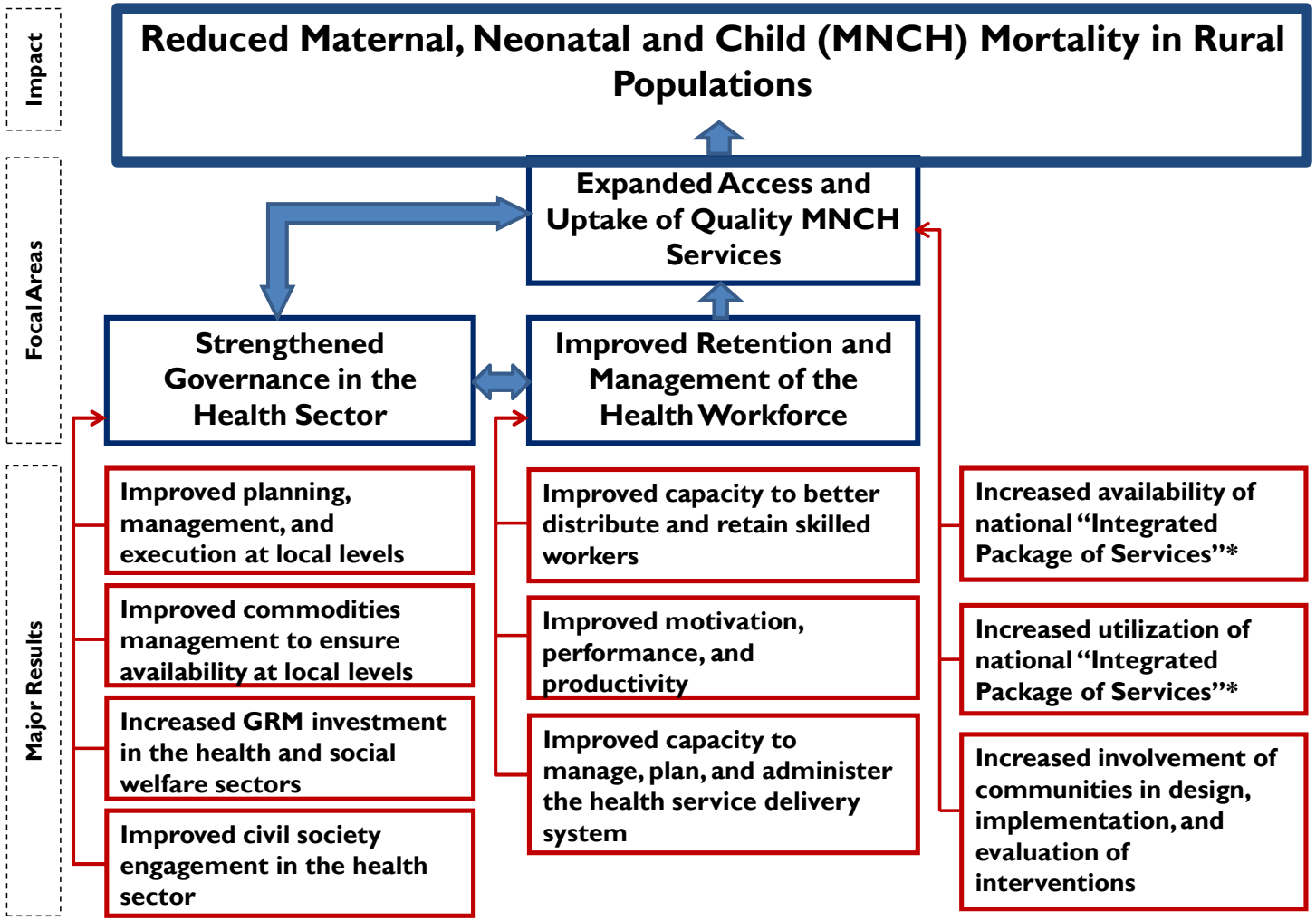
- Be developed in alignment with the national agenda as partners with the INS
- Support the INS in their mandate to set the national research agenda in the health sector through support for:
    - an ethics committee
    - a data management group
    - nationwide surveillance projects

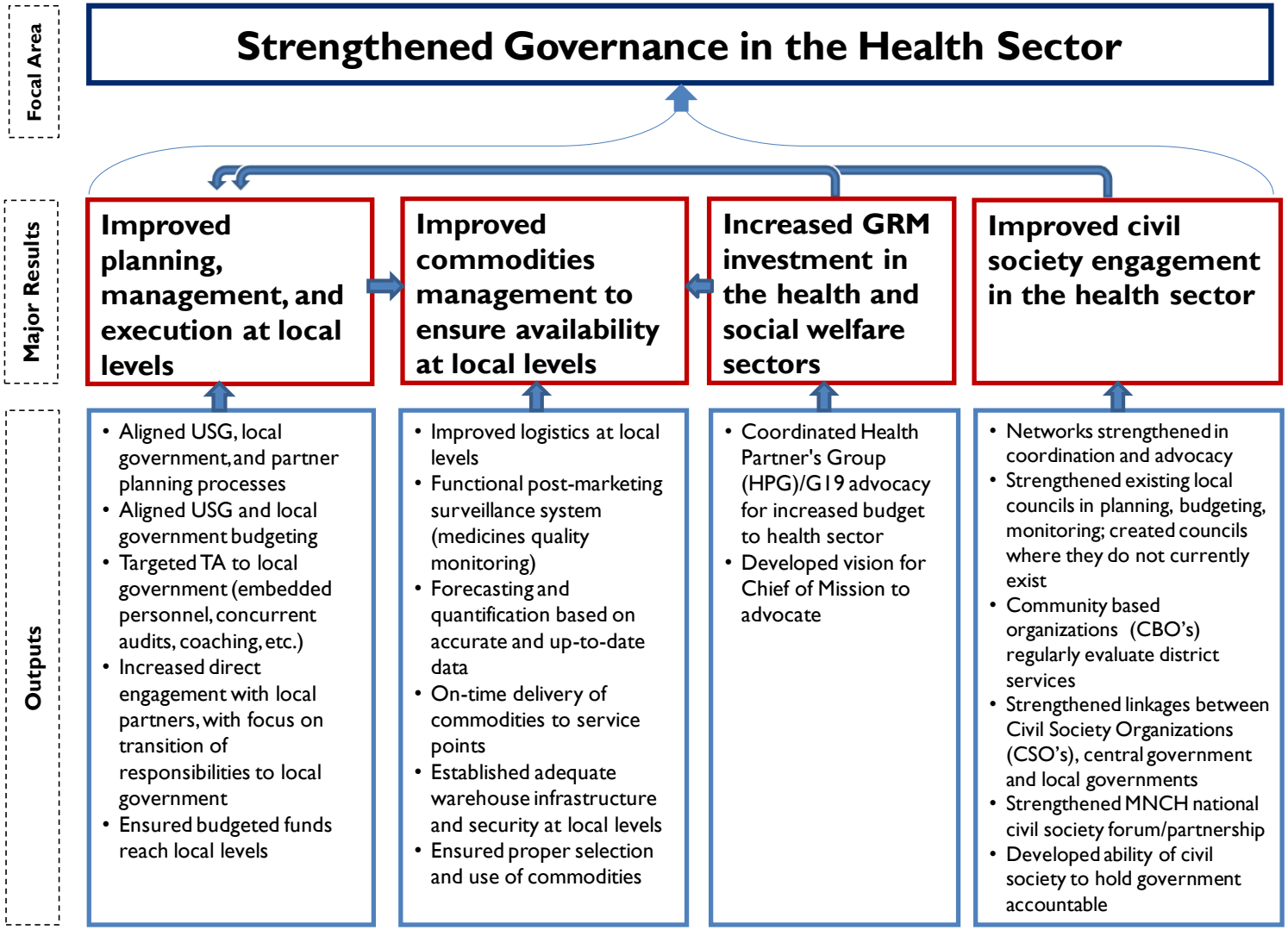
    - research-oriented career tracks within medical and health professions in Mozambique
- Engage government and local institutional researchers
- Draw on strengths of all USG agencies and partners
- Support/align with the USAID Evaluation Policy, HHS Human Subjects Research norms, and the implementation science agenda under PEPFAR
- Be reviewed by in-country interagency evaluation steering committee
- Include evaluations designed to document progress on the roll out of the integrated package of MNCH services and the capture the impact of that roll out on MNCH mortality for rural populations
- Include evaluations with programmatic or geographic focus sufficient to allow measurement of USG contributions to improved MNCH outcomes
- Define how existing Demographic Health Surveillance centers can serve as platforms for innovative evaluation projects
- Support research and public health training through the Medical Education Partnership Initiative (MEPI), the Field Epidemiology and Laboratory Training Program, and local university MPH programs
- Explore how GHI can support the mainstreaming of GHIs gender equity principles and woman and girl focus throughout USG programming

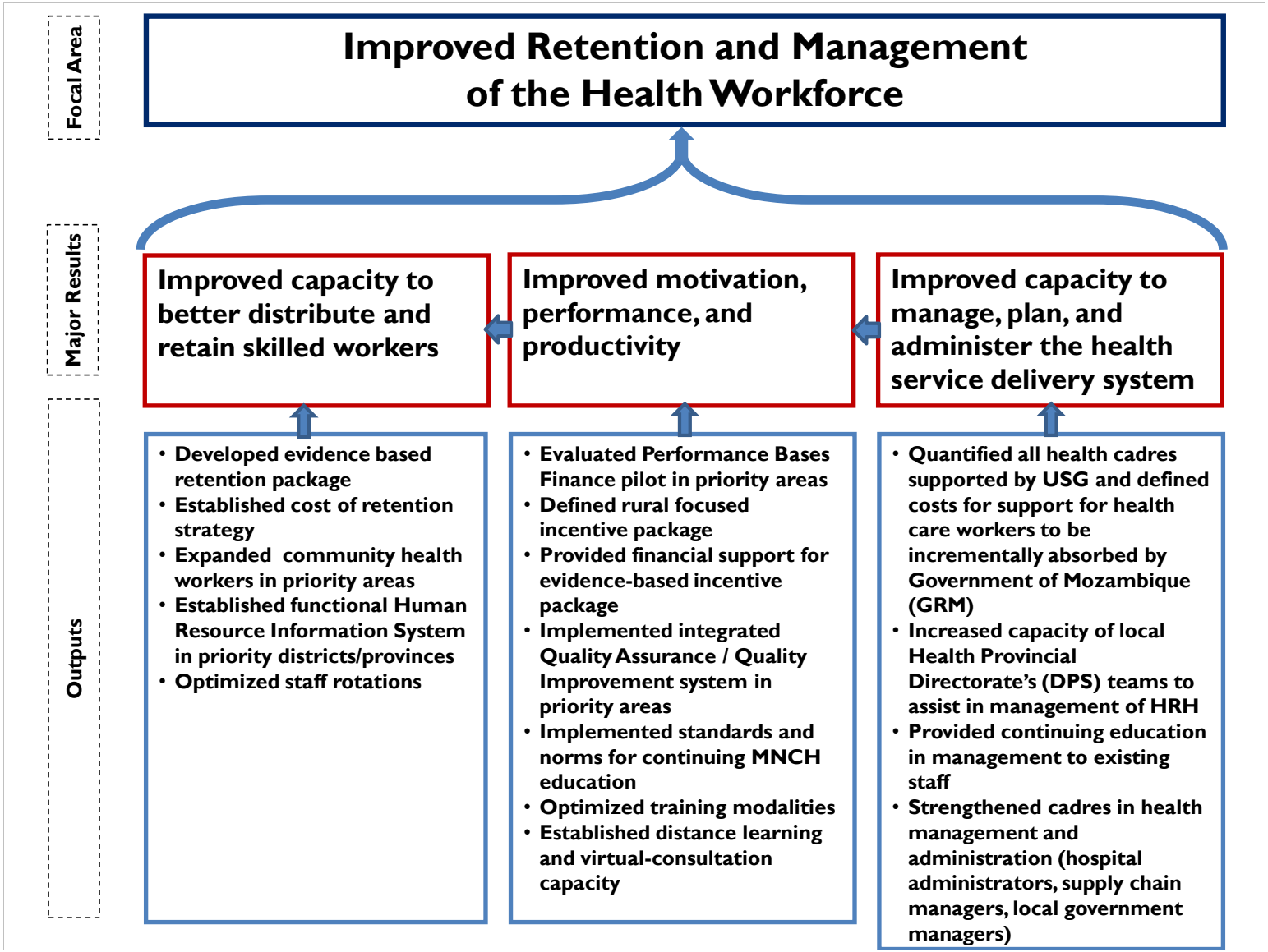
The Learning Agenda is under development and further refinement will take place in coming months.

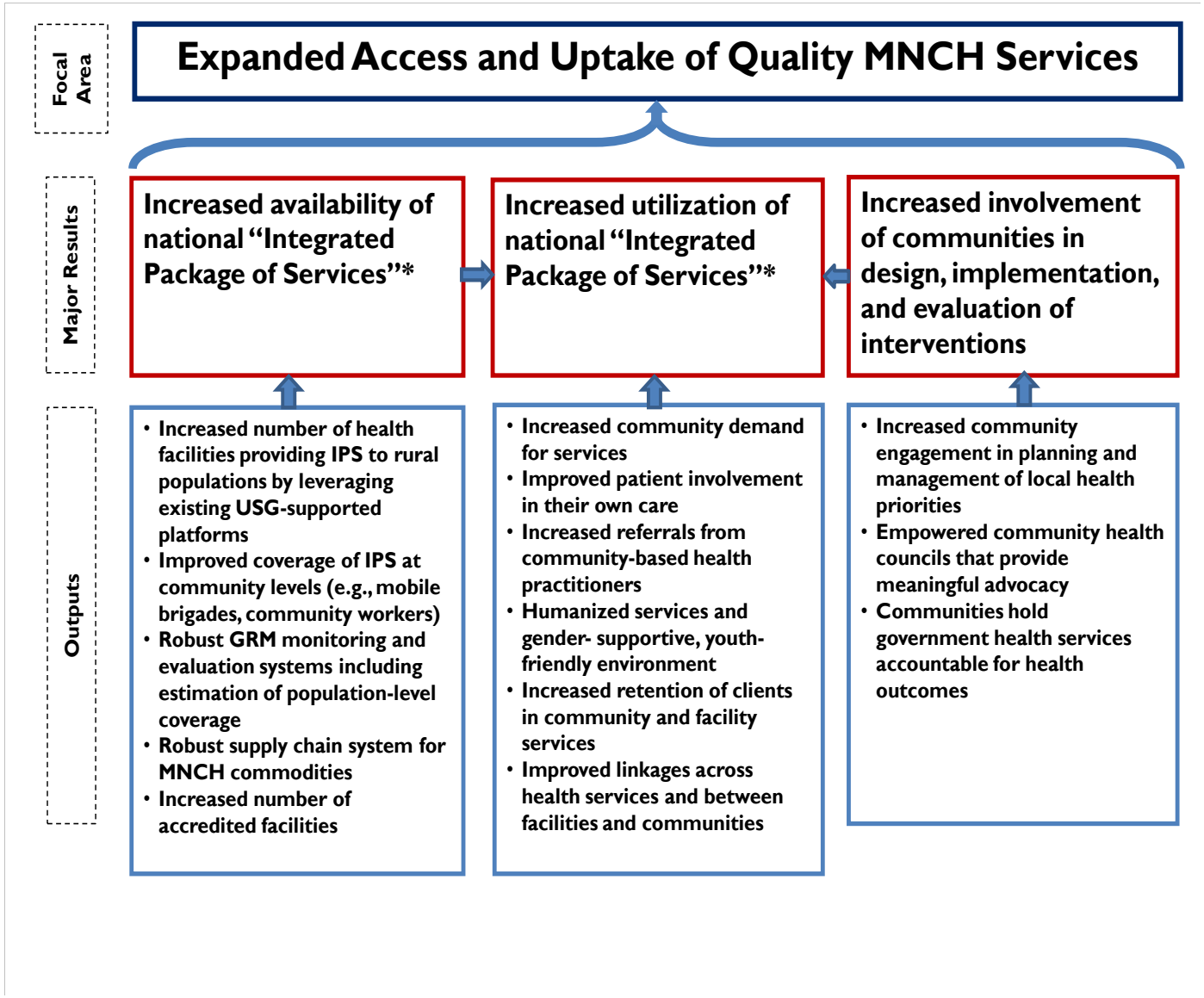
The Results Framework and Strategy Matrix are included as appendices.

APPENDIX 1: RESULTS FRAMEWORK




Focal Area
Strengthened Governance in the Health Sector
Major Results
Improved planning, management, and execution at local levels
Improved commodities management to ensure availability at local levels
Increased GRM investment in the health and social welfare sectors
Improved civil society engagement in the health sector
Outputs
• Aligned USG, local government, and partner planning processes
• Aligned USG and local government budgeting
• Targeted TA to local government (embedded personnel, concurrent audits, coaching, etc.)
• Increased direct engagement with local partners, with focus on transition of responsibilities to local government
• Ensured budgeted funds reach local levels
• Improved logistics at local levels
• Functional post-marketing surveillance system (medicines quality monitoring)
• Forecasting and quantification based on accurate and up-to-date data
• On-time delivery of commodities to service points
• Established adequate warehouse infrastructure and security at local levels
• Ensured proper selection and use of commodities
• Coordinated Health Partner's Group (HPG)/G19 advocacy for increased budget to health sector
• Developed vision for Chief of Mission to advocate
• Networks strengthened in coordination and advocacy
• Strengthened existing local councils in planning, budgeting, monitoring; created councils where they do not currently exist
• Community based organizations (CBO's) regularly evaluate district services
• Strengthened linkages between Civil Society Organizations (CSO's), central government and local governments
• Strengthened MNCH national civil society forum/partnership
• Developed ability of civil society to hold government accountable


Focal Area
Improved Retention and Management of the Health Workforce
Major Results
Improved capacity to better distribute and retain skilled workers
Improved motivation, performance, and productivity
Improved capacity to manage, plan, and administer the health service delivery system
Outputs
• Developed evidence based retention package
• Established cost of retention strategy
• Expanded community health workers in priority areas
• Established functional Human Resource Information System in priority districts/provinces
• Optimized staff rotations
• Evaluated Performance Bases Finance pilot in priority areas
• Defined rural focused incentive package
• Provided financial support for evidence-based incentive package
• Implemented integrated Quality Assurance / Quality Improvement system in priority areas
• Implemented standards and norms for continuing MNCH education
• Optimized training modalities
• Established distance learning and virtual-consultation capacity
• Quantified all health cadres supported by USG and defined costs for support for health care workers to be incrementally absorbed by Government of Mozambique (GRM)
• Increased capacity of local Health Provincial Directorate's (DPS) teams to assist in management of HRH
• Provided continuing education in management to existing staff
• Strengthened cadres in health management and administration (hospital administrators, supply chain managers, local government managers)


Focal Area
Expanded Access and Uptake of Quality MNCH Services
Major Results
Increased availability of national "Integrated Package of Services"*
Increased utilization of national "Integrated Package of Services"*
Increased involvement of communities in design, implementation, and evaluation of interventions
Outputs
• Increased number of health facilities providing IPS to rural populations by leveraging existing USG-supported platforms
• Improved coverage of IPS at community levels (e.g., mobile brigades, community workers)
• Robust GRM monitoring and evaluation systems including estimation of population-level coverage
• Robust supply chain system for MNCH commodities
• Increased number of accredited facilities
• Increased community demand for services
• Improved patient involvement in their own care
• Increased referrals from community-based health practitioners
• Humanized services and gender- supportive, youth-friendly environment
• Increased retention of clients in community and facility services
• Improved linkages across health services and between facilities and communities
• Increased community engagement in planning and management of local health priorities
• Empowered community health councils that provide meaningful advocacy
• Communities hold government health services accountable for health outcomes

APPENDIX 2: STRATEGY MATRIX

<table>
<tr><th colspan="2">FOCUS AREA 1: Strengthened Governance in the Health Sector</th></tr>
<tr><td colspan="2">CHALLENGES & OPPORTUNITIES</td></tr>
<tr><td colspan="2">• Highly dependent and externally influenced health sector--external resources or donor support was 70% of state budget in 2010
• Decreased allocation of state resources to health sector as a percentage of state budget, despite being a signatory to Abuja Declaration
• Inefficient distribution and use of available scarce resources- Planning, identification of needs, budgeting, and managing priorities
• Weak GRM capacity to lead the resource allocation process; resources have not yet reached decentralized levels
• Inability to fully make use of international initiatives like Global Fund
• Lack of financial capacity for prompt acquisition of drugs, reagents and surgical material
• Frequent and widespread commodity stock-outs and human resources are not strategically deployed
• Weak participation of civil society in decision making, planning, and resource allocation and little access to information
• GRM decentralization policy in place to strengthen district as planning unit with local state administration levels linking to communities, but weak implementation</td></tr>
<tr><td>CURRENT APPROACH</td><td>APPROACH UNDER GHI</td></tr>
<tr><td>Historically, the Mozambican public sector, including health, has been highly centralized with limited authority to sub-national administration levels to adequately address the needs of the local population. USG support has also been more centralized, for example to the GRM’s central commodities management unit, central level planning and finance units within the MOH, as well as building financial management and capacity of implementing partners. In 2010, the USG team made a strategic shift toward more decentralized engagement with the GRM which resulted in creation of USG provincial coordination teams to strengthen joint planning processes with the GRM and coordination among the GRM, U.S. and implementing partners at local levels.</td><td>The USG, with significant bilateral investments, is undergoing a shift in how we interface with the public health system to support country ownership. The aim is to increase not only alignment with but also use of government systems as a way of building a better governed and sustainable health system. Under GHI, the USG will intensify efforts to support health sector decentralized planning and budgeting, improve public financial and commodity management and enhance civil society engagement in decision making processes. The USG is expanding its current work with the GRM’s central commodities management unit to incorporate a decentralized approach to supporting the commodity and logistics system that will ensure key commodities are provided to local facilities and communities where they are needed. To support coordinated and complementary central, provincial, and district level plans and priority allocation of USG investments at all levels under GHI, the USG will increase its support to decentralized planning, management and execution to ensure health priorities and resources at local levels respond to local needs, and contribute to greater transparency and accountability in the planning and budgeting process.</td></tr>
<tr><td colspan="2">ALIGNMENT WITH GHI PRINCIPLES BY</td></tr>
<tr><td colspan="2">• Strengthening country ownership and health systems through support for the GRM decentralization strategy, with additional opportunities to strengthen data for decision making, community and civil society engagement, and public financial management
• Building on the U.S. comparative advantage within Mozambique's donor community to leverage existing U.S. partners working at local levels to strengthen decentralized planning and budget authorities and ensure greater</td></tr>
</table>

transparency, accountability and efficiency in the allocation of health resources	
❶ MAJOR RESULT	**MEASURING IMPACT**
Improved planning, management, and execution at local levels	In accord with the principles of country ownership and sustainability under GHI and the "Third One", USG Mozambique will measure impact of its GHI focal area programming based on the Government of Mozambique's National M&E Matrix for the Health Sector (QAD Saude). Process, output, and outcome indicators for specific USG activities will support the impact measures defined by GRM. These impact measures overlap across focal areas and are delineated in a separate matrix for clarity. See M&E Matrix.
Priority Activity Milestones:	
A. USG provincial coordination teams completed provincial mapping of partners and activities by October 2011. B. USG health partner work plans are aligned with provincial and district priorities (PES plans) by August 2012. C. Standardized, inter-agency quarterly reports which capture U.S. health expenditures and routine program monitoring at central and provincial levels are implemented by May 2012. D. Effective TA policy with MOH established by June 2013.E. Increase execution of direct provincial funding agreements by 2013.	
❷ MAJOR RESULT	**MEASURING IMPACT**
Improved commodities management to ensure availability at local levels	In accord with the principles of country ownership and sustainability under GHI and the "Third One", USG Mozambique will measure impact of its GHI focal area programming based on the Government of Mozambique's National M&E Matrix for the Health Sector (QAD Saude). Process, output, and outcome indicators for specific USG activities will support the impact measures defined by GRM. These impact measures overlap across focal areas and are delineated in a separate matrix for clarity. See M&E Matrix.
Priority Activity Milestones:	
A. Regular coordination meetings between commodities stakeholders established by June 2012 B. Effective measures to ensure commodity delivery to local levels established by January 2012 C. Clear roles/responsibilities for key commodity stakeholders at central and decentralized levels developed by October 2011 D. Pharmaceutical and Logistics Master Plan approved by February 2012 E. Logistics procedures training to all relevant MOH staff down to health facility level provided by December 2011 F. Logistics management information system (LMIS) consistently in use in the three focal provinces and reporting data back to central levels by June 2012. G. Strategy to mitigate the impact of delayed or cancelled major financing scheme for commodities (i.e. Global Fund or World Bank) developed by October 2011	
❸ MAJOR RESULT	**MEASURING IMPACT**
Increased GRM investment in the health and social welfare sectors	In accord with the principles of country ownership and sustainability under GHI and the "Third One", USG Mozambique will measure impact of its GHI focal area programming based on the Government of Mozambique's National M&E Matrix for the Health Sector (QAD Saude). Process, output, and outcome indicators for specific USG activities will support the impact measures defined by GRM. These impact measures overlap across focal areas and are delineated in a separate matrix for clarity. See M&E Matrix.

Priority Activity Milestones:	
A. Increased the number of joint USG/health donors/G19 advocacy statements in order to increase budget to health sector by June 2012. B. Standardized training in financial management implemented in the three focal provinces by October 2013.	
❹ **MAJOR RESULT**	**MEASURING IMPACT**
Improved civil society engagement in the health sector	In accord with the principles of country ownership and sustainability under GHI and the "Third One", USG Mozambique will measure impact of its GHI focal area programming based on the Government of Mozambique's National M&E Matrix for the Health Sector (QAD Saude). Process, output, and outcome indicators for specific USG activities will support the impact measures defined by GRM. These impact measures overlap across focal areas and are delineated in a separate matrix for clarity. See M&E Matrix.
Priority Activity Milestones:	
A. U.S. Health and Civil Society Engagement Strategy for Mozambique to guide U.S. investments developed by November 2011. B. Increased financing mechanisms to support national and community advocacy networks (non-service delivery) by June 2012. C. Local institutions that could be direct recipients of funding to provide technical assistance and manage sub-grants to civil society partners and identify strategic opportunities (e.g. Global Fund Round 9, professional nursing councils, etc.) identified by December 2012. D. Strengthened participation and effectiveness of MNCH national civil society forum/partnership by December 2012. E. New Annual Program Statement to provide direct funding to local civil society organizations launched by December 2012.	

FOCUS AREA 2: Improved Retention and Management of the Health Workforce

CHALLENGES & OPPORTUNITIES

- Mozambique is one of the countries most affected by the human resources for health (HRH) crisis
- Very low health worker to population ratios: Approx. 3 doctors and 21 nurses per 100,000 people
- Only 843 doctors in all of Mozambique; of these, only approx. 300 are outside the capital
- Low absorption of HCWs into the government system-- remains a key barrier to increased numbers of health workers with only 1000 government positions for 2000 graduates
- Inadequate HR systems for tracking, motivating and retaining staff is weak, especially for rural facilities
- High turnover and low motivation of health care workers
- Weak institutional capacity for retention of qualified human resources particularly for areas such as finance, informatics, and supply chain management
- Human resources are not strategically deployed with uneven distribution of health workers central versus provincial versus district level
- GRM is currently poised to revise their procedures for health workforce recruitment, allocation, deployment and retention

CURRENT APPROACH	**APPROACH UNDER GHI**
Currently, USG investments in HRH focus on in-service skill updates and pre-service education, such as curriculum development and scholarships for	Under GHI, the USG HRH portfolio will continue to increase attention to recruitment, deployment, and retention for essential health worker cadres critical to

clinical staff. Current activities focus on increasing the number of health care workers (HCW) and improving the quality of pre-service education. Historically, the USG has supported the growth of an informal cadre of "activistas".	reaching rural populations, as well as training and deploying non-clinical cadres such as health administrators, managers, and supply chain logisticians. This new approach will complement continued support for training activities that help ensure skilled HCW remain in the public health system, benefit from appropriate supervision and management, and are empowered to provide high quality MNCH services. This shift complements decentralization efforts by strengthening the host government human resource management and other priority cadres to support effective planning of resources at local levels.

ALIGNMENT WITH GHI PRINCIPLES BY

- Strengthening country ownership and health systems through support to a GRM retention strategy and a national human resource information system (HRIS) for country management and deployment of adequate human resources to address needs at all levels
- Building on the U.S. comparative advantage within donor community and leverages other bilateral and multilateral donor investments

❶ MAJOR RESULT	MEASURING IMPACT
Improved capacity to better distribute and retain skilled workers	In accord with the principles of country ownership and sustainability under GHI and the "Third One", USG Mozambique will measure impact of its GHI focal area programming based on the Government of Mozambique's National M&E Matrix for the Health Sector (QAD Saude). Process, output, and outcome indicators for specific USG activities will support the impact measures defined by GRM. These impact measures overlap across focal areas and are delineated in a separate matrix for clarity. See M&E Matrix.

Priority Activity Milestones:

A. Key factors in retention in rural areas identified by June 2013.
B. Cost of retention strategy established by December 2013.
C. CHWs in priority areas expanded through leveraging the "Reach Every District" program platform by December 2012.
D. Evaluation of first phase roll-out of MOH CHW program conducted by December 2013.
E. Architecture and foundation for an HRIS system for deployment finalized by December 2012.
F. Assessment of existing information sources related to staff rotation practices and policies conducted by June 2012.

❷ MAJOR RESULT	MEASURING IMPACT
Improved motivation, performance, and productivity	In accord with the principles of country ownership and sustainability under GHI and the "Third One", USG Mozambique will measure impact of its GHI focal area programming based on the Government of Mozambique's National M&E Matrix for the Health Sector (QAD Saude). Process, output, and outcome indicators for specific USG activities will support the impact measures defined by GRM. These impact measures overlap across focal areas and are delineated in a separate matrix for clarity. See M&E Matrix.

Priority Activity Milestones:

A. Evaluation of "minimal" rural incentives package conducted by March 2013.
B. Roll-out of standards-based management program implemented by December 2013.
C. MOH defined standards for continuing education in MNCH established and implemented by December 2013.
D. Integrated Quality Assurance / Quality Improvement system implemented in priority areas by June 2012.
E. Virtual consultations between rural health posts piloted by June 2012.
F. PBF pilot evaluated by April 2012.

❸ MAJOR RESULT	MEASURING IMPACT
Improved capacity to manage, plan, and administer the health service delivery system	In accord with the principles of country ownership and sustainability under GHI and the "Third One", USG Mozambique will measure impact of its GHI focal area programming based on the Government of Mozambique's National M&E Matrix for the Health Sector (QAD Saude). Process, output, and outcome indicators for specific USG activities will support the impact measures defined by GRM. These impact measures overlap across focal areas and are delineated in a separate matrix for clarity. See M&E Matrix.

Priority Activity Milestones:

A. Plan to support in-service training in management and administration developed by October 2011.
B. Continuing education in management to existing staff provided by December 2013.
C. Pre-service programs in hospital administration provided by December 2012.
D. All health cadres supported by USG quantified and costs defined for support for health care workers who will be incrementally absorbed by GRM by June 2012.

FOCUS AREA 3: Expanded Access and Uptake of Quality MNCH Services

CHALLENGES & OPPORTUNITIES

• In Mozambique, maternal, neonatal and child mortality is impacted by the concurrent HIV/AIDS epidemic; high rates of malaria, tuberculosis and other infectious diseases; water and food insecurity; and lack of access to quality primary health care services.
• USG largest donor in the health sector; yet, historically, mandate of USG partners was limited to specific diseases or conditions with few incentives to support integrated services which led to vertical approach to support of health care system and missed opportunities to maximize USG investment.
• GRM requested that the USG align its partners with their strategic vision to strengthen primary health care as outlined by the Integrated Package of Services and Continuing Education in Reproductive Health and Maternal, Neonatal and Infant Health (IPS).

CURRENT APPROACH	APPROACH UNDER GHI
Historically, mandates of USG partners were limited to addressing specific diseases or conditions with limited flexibility to support an integrated health approach. In 2010, the USG realigned the mandate of all of its clinical partners, regardless of funding stream, to broadly align support with the GRM's	Under GHI, USG implementing partner support previously developed through existing investments (in particular PEPFAR), will be leveraged to support broader integrated approach for improved MNCH outcomes. In alignment with the principle of country ownership, the USG will redirect current implementing partners and programs, regardless of funding stream, to more holistically support and build MOH

Integrated Package of Services for improved MNCH outcomes. The MOH has finalized the integrated package and is now in the early stages of rolling out implementation throughout the country at all levels of service delivery.	capacity to implement the IPS. Specifically, the USG will accelerate implementation of the IPS in primary health facilities and communities supported by current USG partners and will identify new opportunities to build the capacity of local government and civil society to improve the linkages between communities and primary health facilities.
ALIGNMENT WITH GHI PRINCIPLES BY	
• Utilizing existing USG partners and investments to scale an integrated package of proven, cost-effective and life-saving interventions • Strengthening country ownership and health systems through support for the GRM strategy to deploy an Integrated Package of Services • Leveraging the USG comparative advantage within the donor community • Providing an opportunity to contribute to the GHI learning agenda by evaluating "smart integration" approach	
❶ **MAJOR RESULT**	**MEASURING IMPACT**
Increased availability of national "Integrated Package of Services"	In accord with the principles of country ownership and sustainability under GHI and the "Third One", USG Mozambique will measure impact of its GHI focal area programming based on the Government of Mozambique's National M&E Matrix for the Health Sector (QAD Saude). Process, output, and outcome indicators for specific USG activities will support the impact measures defined by GRM. These impact measures overlap across focal areas and are delineated in a separate matrix for clarity. See M&E Matrix.
Priority Activity Milestones:	
A. Standardized training and supervision tools to support IPS-MNCH finalized and implemented by June 2012. B. IPS-MNCH facility based registers and reporting forms revised and implemented to support government reporting and measure progress in delivering the IP-MNCH by June 2012. C. IPS data incorporated into MOH routine M&E systems by June 2013. D. Program review of national PMTCT program completed by December 2011 and impact assessment of national PMTCT program completed by December 2012. E. Scope of existing PEPFAR partners to support implementation of IPS activities defined and expanded by October 2011.F. Strategy for capturing IPS activities at community level finalized by June 2012.	
❷ **MAJOR RESULT**	**MEASURING IMPACT**
Increased utilization of national "Integrated Package of Services"	In accord with the principles of country ownership and sustainability under GHI and the "Third One", USG Mozambique will measure impact of its GHI focal area programming based on the Government of Mozambique's National M&E Matrix for the Health Sector (QAD Saude). Process, output, and outcome indicators for specific USG activities will support the impact measures defined by GRM. These impact measures overlap across focal areas and are delineated in a separate matrix for clarity. See M&E Matrix.
Priority Activity Milestones:	

A. "Demand side" interventions to increase utilization of packaged systems piloted by March 2012. B. IPS strategy included in scope of USG-supported patient empowerment groups by September 2012. C. Formal lines of communication between community structures and health facilities established by June 2012. D. Novel strategies for rural referral and transportation piloted and evaluated by December 2012. E. Coordination of meetings between MOH programs for IPS institutionalized by January 2012. F. USG health promotion strategy completed by June 2012.

❸ **MAJOR RESULT**	**MEASURING IMPACT**
Increased involvement of communities in design, implementation, and evaluation of interventions	In accord with the principles of country ownership and sustainability under GHI and the "Third One", USG Mozambique will measure impact of its GHI focal area programming based on the Government of Mozambique's National M&E Matrix for the Health Sector (QAD Saude). Process, output, and outcome indicators for specific USG activities will support the impact measures defined by GRM. These impact measures overlap across focal areas and are delineated in a separate matrix for clarity. See M&E Matrix.
Priority Activity Milestones:	
A. Local community councils trained on using and understanding health data and routine fora for discussion established by June 2012. B. Curriculum for health committee data management and analysis developed by December 2011. C. Mechanisms to allow for communities to discuss health facility performance and community health outcomes evaluated and implemented (i.e. health facility scorecards, RED Strategy) by December 2012.	

APPENDIX 3: MONITORING AND EVALUATION MATRIX

M&E Matrix								
USG Moz Impact Goal Under GHI	**USG Moz Focal Area Goal**	**GRM Priority Impact Goal (Aligned with MDG 4,5,6,8)**	**GRM Outcome Indicator**	**Baseline (Source,Year)**	**GRM National Target (Year)**	**Process, Output and Outcome Indicators**	**GRM National Target (2014)**	**Data Source**
Reduced Child and Newborn Mortality in Rural Populations	Expanded Access and Uptake of Quality MNCH Services	Reduce child and infant mortality	Under- Five Mortality Rate	157 per 1000 (MICS, 2008)	108 per 1000 (2015)	Proportion of children under five years old with fever in the last two weeks who received treatment with ACTs within 24 hours of onset of fever	95%	National MNCH Data
						% of health centers providing growth monitoring (0-1; 1-4; urban/rural)	TBD	National MNCH Data
						% of children under age 1 completely vaccinated (baseline 60%)	80%	National MNCH Data
						% of HIV-exposed infants receiving ARV prophylaxis for PMTCT in L&D (baseline 51% 2009)	83%	National MNCH Data
Reduce Maternal Mortality in Rural Populations	Expanded Access and Uptake of Quality MNCH Services	Reduce the Maternal Mortality Ratio	Maternal Mortality Ratio	408 per 100,000 (DHS, 2003)	250 per 100,000 (2015)	% of women who received at least 2 doses of IPTp at ANC (baseline 67% 2009)	88%	National MNCH Data
						% of health centers with maternity waiting	50%	National MNCH Data

						houses (baseline 41% 2009)		
						% of new clients using modern family planning methods	19%	National MNCH Data
						Mean number of pre-natal visits per pregnancy	TBD	National MNCH Data
						% of women with unmet contraceptive need (baseline 53% 2009)	30%	National MNCH Data
						% of institutional deliveries (baseline 55% 2009)	66%	National ART Program
Reduced Child Mortality in Rural Populations	Expanded Access and Uptake of Quality MNCH Services	Reduce the incidence of severe malaria in children under 5	Rate of severe malaria in children under 5	55 per 10,000 (2001)	33.6 per 10.000 (2012)	Proportion of children under five years old with fever in the last two weeks who received treatment with ACTs within 24 hours of onset of fever	95%	National Malaria Program
			% of pregnant women and children under 5 sleeping under an ITN	7.3% of pregnant women --- 6.7% of children under 5	85% (2012) --- 85% (2012)	% of pregnant women sleeping under an ITN the night before survey --- % of children under 5 sleeping under an ITN the night before survey	85%	2011 DHS; MICS 2013-2014
Reduced Child Mortality in Rural Populations	Expanded Access and Uptake of Quality MNCH Services	Reduce the risk of maternal to child transmission	% of infants born to HIV+ mothers who are HIV+ (modeled	Baseline to be determined from Demographic Impact Modeling currently in progress		% of health centers providing package of PMTCT services (baseline 2010 85% (909 of 1063)	100%	National MNCH Data

		of HIV	result based on Biannual Demographic Impact Report)			% of HIV+ pregnant women receiving ARV prophylaxis in ANC (baseline 2009 47%)	85%	National MNCH Data
Reduced Maternal Mortality in Rural Populations	Expanded Access and Uptake of Quality MNCH Services	Increase the number of eligible persons receiving antiretroviral treatment	% of eligible HIV+ persons receiving ART according to National Protocol	218,991 (National ART Program 2010)	400,000	Number of ART patients with access to community-based adherence groups	50% of patients on ART	Pilot/Assessment USG with Nat ART Program
						Number of pediatric patients receiving ART (baseline17,395, QAD SAUDE 2010)	39,743	National ART Program
Reduced Maternal, Newborn, and Child Health in Rural Populations	Expanded Access and Uptake of Quality MNCH Services	Increase access to quality health services and reduce inequities in health sector	% population with access to health facility defined as less than 30 min travel on foot	39% (2010)	Nat'l as yet undefined	Completion of assessment on motivators for retention with focus on rural health workers	Completed and Disseminated 2013	N/A
	Improved Retention/ Management of Health Workforce		Ratio of outpatient visits per capita in rural versus urban districts	1.2 (2010)	1.0 (2014)	# new community health workers trained in administration of IPS	TBD	HR Assessment
	Expanded Access and Uptake of Quality MNCH Services --- Strengthened Governance in the Health Sector					# new community health workers deployed in MOH system	TBD	HR Assessment
						# of provinces and districts with information in and access to national HRIS system; districts disaggregated by urban/rural	Provinces: 11	HR Assessment
			% of Health Centers that have	Water 59% (2010)	Nat'l as yet undefined	TBD under USG infrastructure priority plan in alignment with	TBD	Pending GRM Infrastructure priorities list

			electricity and running water	Electricity 45% (2009)	Nat'l as yet undefined	GRM	TBD	
	Improved Retention/ Management of Health Workforce	Improve the availability of key resources that contribute to quality health services across all populations	Ratio of health workers to population	63.4 per 100,000 (MOH 2010)	Nat'l as yet undefined	% of rural districts fully staffed based on local HR plan	TBD	GRM HR Annual Program Report
			Number of health workers graduating from pre-service institutions	758 (APR 2010)	2698	Number of provinces/districts completing all required audits within the deadline	TBD	USG Program Monitoring
	Strengthened Governance in the Health Sector	Strengthen and improve financial management within the health sector at all levels	Expenditures as % of approved budget under health sector	90%	100%	% of audits at provincial and district level without negative results	80%	Audit Results
			% of audits completed without negative results	GRM reporting	Not Defined	% of USG funds provided directly to GRM (baseline PEPFAR COP 2011 3.7%)	5%	USG Budget Data
		Improve the predictability of external funds to the health sector to harmonize MOH and partner activities	% of partners bilateral and multilateral funds in 3 year (vs. 1 year) commitments			% of USG funds using GRM financial systems (baseline 0% 2011)	3%	USG Budget Data
						% of GRM budget allocated to health sector (baseline 7%)	15%	GRM
						# Districts/localities implementing a scorecard or accountability tool for performance of health system	0	64
		Improve health				USG Strategy for Civil Society Engagement	0	Yes/No

		promotion and community involvement (National Strategic Plan for the Health Sector 2007-2012)				completed and approved by stakeholders		
			64 District Health Councils established and mobilized (50% of districts)	TBD		# of districts in which civil society participates in health sector planning and monitoring processes on a regular schedule and at least once per month	TBD	TBD
						# provinces/districts with at least one civil society network engaged in health issues	TBD	TBD
						# civil society organizations receiving USG funding through partner sub-agreements (by partner, province, district)	TBD	TBD
						# civil society organizations receiving direct USG funding (by province, district)	TBD	TBD

APPENDIX 4: CONCEPT AND STRUCTURE OF THE INTEGRATED PACKAGE OF SERVICES

In Mozambique, the Maternal, Neonatal and Child, morbidity and mortality reduction strategy addresses the implementation of key effective interventions organized in packages across the continuum of care. The continuum of care for MNCH refers to continuity of individual care, throughout the life cycle; adolescence, pre-pregnancy, pregnancy, childbirth, post-partum, newborn and childhood care, and also between places of care giving (including household and communities, outpatient and outreach services, and clinical care settings). The Integrated Package of Services is defined to be delivered through community and facilities channels to assure adequacy and quality of care throughout the lifecycle of mothers, babies, and children.

The Guiding Principles of the Integrated Package of Services:

- Ensuring universal access of basic lifesaving services, family planning (FP), Post-abortion care, maternal and newborn and child health care, with special attention to the most vulnerable groups
- Ensuring women and communities participation in MNCH programs
- Integration of MNCH services and reproductive health including HIV prevention, care, and treatment
- Pursuing social justice and poverty reduction to address health inequities
- Facilitate the protection and fulfillment of human rights of women, men adolescents, newborn and children
- Respecting the basic values of choice, dignity, diversity and equality
- Address gender and cultural sensitivities

The interventions/services are organized in 4 packages: Community package, Minimal package at the first facility level, comprehensive package for the first referral level (2nd level of care), and specialized a package for the 3rd and 4th levels of facility services. Table 1 outlines the type of package, the service delivery point, and the cadre of health personal required for each level. Table 2 provides a summary of the key activities by program area and Table 3 gives an illustrative list of key interventions/services for each of the four packages by programmatic area.

Table 1 -Summary of the Four Packages of Services, Service Deliver Points and Providers

Package	Service Delivery Point	Level of Provider
Community	**Community**	Traditional birth Attendent Agente Polivalente Elementar (APE)
	Health Posts	APE
Minimal	**Health Posts**	Elmentary Midwife Elementary Nurse
	Type II Rural Health Center	Elementary Midwife Elementary Nurse Nutrition agente
Comprehensive	**Type II Rural Health Center**	Medical Technician or Medical Assistant Basic Midwife Basic Nurse Basic Nurse or Agent
	Type I Health Center Rural	Doctor, Technician or Medical Agent Basic Midwife Medical Prevention Agent Basic Nurse
	Type C URBAN Health Center	Basic midwife Medical Prevention Agent Basic Nurse
	Type II Urban Health Center	Medical Technician Basic midwife Medical Prevention Agent Basic Nurse
	Type A Urban Health Center	Doctor, Medical technician and MCH Agent Nurse Basic midwife Medical prevention Agent Basic Nurse
	District Hospital	Doctor, Medical technician and MCH Agent Basic midwife Medical prevention Agent Basic Nurse
Specialized	**District Hospital**	Doctor Medical Technician Obstetric Surgery technician Obstetric Nurse Laboratory Technician or Agent Basic or Midlevel MCH nurse Basic or midlevel nurse

	Rural Hospital	Doctor Medical Technician Obstetric Surgery technician Obstetric Nurse Laboratory Technician or Agent Basic or Midlevel MCH nurse Basic or midlevel nurse
	General Hospital	Doctor Medical Technician Obstetric Surgery technician Obstetric Nurse Laboratory Technician or Agent Basic or Midlevel MCH nurse Basic or midlevel nurse
	Provincial Hospital	All cadres
	Central Hospital	All cadres

Table 2 -Summary of Key interventions within the Integrated Package by Program

Program Area	Level of the Health System	Summary Key Activities
Reproductive Health and FP	Community and Facilities	Information education and communication (IEC) life style, Hygiene, Nutrition, Immunization, delay first pregnancy, contraceptives, STI/HIV prevention, peri-conceptual Iron and folic acid supplementation, cervical and breast cancer screening, Malaria and TB prevention screening and treatment
Pregnancy	Community	Health promotion, condom, hand –held cards and emergency cards, ITN and Partum Preparedness
	Health facilities	Antenatal Care 4 visits (WHO guidelines), Nutrition Assessment and care Iron and folic acid supplementation, Malaria prevention, STI and Syphilis screening and treatment, deworming, PMTCT, Immunization and TB screening
Childbirth	Community	Companion of choice, Earlier detection of warning signs, Infection Prevention, clean delivery and Misoprostol,
	Health Facilities	Social support, Skilled attendance, Pantograph, Infection Prevention, Basic and Comprehensive emergency Obstetric care, Management of premature ruptured membranes , AMTSL
Postnatal	Community	Support for breastfeeding, care seeking for complication PPH and infection, advise and provision of FP, Referral within 24 hours
	Health Facilities	+ Initiation of ART, Treatment of maternal infection and PPH
New-born	Community	Oral antibiotic , skin to skin contact first hour , breastfeeding and thermal protection, ART for PMTCT
	Health facility	Essential New-born care, Immunization and PROM initiation of ART.
Child Intervention	Community and outreach	Exclusive Breastfeeding, Vit A ,, ITNs, Case management of Pneumonia , Enhanced Diarrhoea management , ORS, Zinc , Antibiotics for dysentery
	Health facility	Supplementary food , Immunization including Hib, case management for Acute malnutrition , pneumonia, meningitis and malaria

Table 3 Illustrative List of Services/Interventions by Package Levels

Area	Community Package	Minimal Package	Comprehensive Package	Specialiazed Package
ADOLESCENT AND YOUTH	**Information education and comunication** • IEC Promotion of Hygiene • Hands wash and environmental Health • Education for prevention alcohol abuse, tobacco and other drugs **Immunization and Nutrition** • Counseling for tetanus immunization • Nutritional education and Hygiene • Nutritional Assessment and orientation • Anaemia assessment. • Iron Supplementation and deworming **STI/HIV** • Counselling on delayed sexual debut and HIV prevention • Counseling and testing for HIV • Condom use • Awareness on STI signs **Endemic Disease** • TB screening and Community Dots • Malaria prevention diagnosis first treatment • Identification and referral of other infection disease **Reproductive health** • Health education on safe sex, FP, birth spacing • Enable adolescents of both sex to access the to various reproductive health services through integrated and linked services • Counseling and distribution of contraceptive methods including emergency contraception • Awareness of signs of domestic violence and coerced sex	**Information Education and Communication** • Health Promotion and hygiene (oral, auditive, ocular) **Immunization and Nutrition** • Tetanus immunization • Nutrition Assessment counselling and care and referral of acute and severe malnutrition • Deworming • Anaemia assessment and Iron and folic acid supplementation. **STI/HIV:** • STI screening (Syphilis , syndromic screening and treatment of patients and their partners) • CT including PICT • HIV clinical WHO staging and referral • Referral of cases of Sexual violence for treatment **Endemic Disease:** • TB screening and referral • Treatment for non-complicated Malaria and others infection diseases referral for severe cases **Contraception and Breast and cervical cancer screening:** • Prevention of earlier pregnancy, oral contraception, condom distribution and emergency contraception. • Promotion of self-screening , clinical screening and referral of suspicious cases of disease • Referral of women with HIV older 20 years old for cervical cancer screening **Case management of early pregnancy** • Initial ANC for teenage pregnancy • Post abortion care and referral for complicated cases • Promote partner involvment	**Information Education and Communication and care;** • Mental Health care for alcohol and drug users and referral for specialized care. • Screening and referral for low school performance. • Treatment of Oral Problems **Immunization and Nutrition** • Assessment and treatment of nutritional problems and referral for severe problems s • Assessment of moderate anaemia and referral of severe problems **STI/HIV:** • Screening of STI and treatment • ARV treatment according to MOZ guidelines • Screening for Domestic violence and sexual assault treatment and referral if needed **Endemic Disease** • TB screening and treatment • Malaria treatment and referral for severe cases • Treatment of other infectious diseases and referral of severe cases **Contraception and Breast and cervical cancer screening:** • Breast examination and referral of cases with positive results • Cervical cancer screening with acetic acid , criotherapy and for all HIV + women older than 20 years and referral according to the national guidelines **Earlier Pregnancy and Post-abortion Care :** • ANC including PMTCT and ARV treatment (according to the guidelines and referral of suspect fetal pelvic incompatibility) • Post abortion care and treatment for complicated abortion according to the guidelines .	**General Care** • Treatment on substances abuse • Treatment of cases of alcohol abuse • Mental health and Psychological support **Immunization and Nutrition** • Treatment of moderate and severe malnutrition. **STI/HIV:** • Treatment and care of Severe cases of HIV-SIDA • Treatment and care of cases of Sever cases of sexual violence and abuse and referral to legal ad social services **Endemic Disease** • Treatment and care for complicated Pulmonary TB • Malaria Treatment • Treatment of severe infections diseases **Contraception and Breast and cervical cancer screening** • Treatment of Breast masses and others • Treatment of advanced cervical lesions, colposcopy and LEEP; • Treatment of all medical and surgical condition including • Obstetric Fistulas • Male circumcision • **Teenage pregnancy and Post abortion care** • Post abortion care for complicated abortion

Area	Community Package	Minimal Pakage	Comprehensive Package	Specialized Package
WOMEN AT REPRODUCTIVE AGE	**Information Education and Comunication** • IEC on personnel hygiene and sanitation **Imunization and Nutrition** • Counseling on tetanus immunization • Nutritional Education • Anaemia assessment and referral • Iron and Folic acid supplementation, Deworming (APE) **STI/HIV:** • HIV counseling and testing • HIV/AIDS and ITS prevention counselling and promotion of condom use • Condom Distribuition • Awareness on ITS signs and referral. **Endemic Disease :** • TB screening and Community Dots • Malaria prevention diagnosis and first treatment • Identification and referral of other infection disease **Reproductive Health** • IEC on contraception and Family planning • Counseling on Integrated FP care • Oral contraception only for if the first visit was at the health facility • Identification of post-abortion care cases and referral • Counseling on self-evaluation of breast cancer and referral. • Screening of Domestic violence and referral. • Referral of cases of infertility	**Immunization and Nutrition** • Tetanus Vaccination • Anaemia treatment **STI/HIV** • STI screening (Syphilis, syndromic screening and treatment of patients and their partners) • CT including PICT • HIV clinical WHO staging and referral • Referral of cases of Sexual violence for treatment **Endemic Disease** • TB screening and referral • Treatment for non-complicated Malaria and others infection diseases referral for severe cases **Contraception and Breast and cervical cancer screening and other Reproductive Health conditions** • Family planning (Injectable DEPO, oral contraception condom distribution and emergency contraception). • Male involvement • Promotion of self-screening , clinical screening and referral of suspicious cases of disease • Referral of HIV + women with 20+years old for cervical cancer screening • Referral for women older than 30 years for cervical cancer screening • Identification and referral of cases of infertility **Post Abortion Care** • Post abortion care for non-complicated case of abortion and referral for complicated cases	**Immunization and Nutrition** • Assessment of cases of moderate anaemia. **STI/HIV:** • Screening for STI and treatment • ARV according to the national guidelines • Screening for Domestic violence and sexual assault treatment and referral if needed **Endemic Disease** • TB screening and treatment • Malaria treatment and referral for severe cases • Treatment of other infectious diseases and referral of severe cases **Contraception and Breast and cervical cancer screening :** • Counselling and provision of temporary and Permanent methods (Tubal Ligation, implants, post-partum IUD and tubal ligation) • Breast examination and referral of cases with positive results • Within the FP services screening with acetic acid, criotherapy for all women older than 30 years and referral according to the national guidelines. • Treatment of infertility **Post abortion care :** • Post abortion care and treatment for complicated abortion according to the guidelines	**Immunization and Nutrition** • Treatment of severe case of anaemia **STI/HIV** • Treatment and care of severe cases of HIV • Treatment and care of cases of severe cases of sexual violence and abuse and referral to legal and social services **Contraception and Breast and cervical cancer screening** • Counselling and provision of Permanent methods (Tubal Ligation, implants, post-partum IUD) • Treatment of Breast masses and others • Treatment of advanced cervical lesions, colposcopy, and LEEP; • Treatment of all medical and surgical condition including Obstetric Fistulas • Male circuncision **Post abortion care** • Post abortion care for complicated abortion

		Information Education and Communication • Hygiene Promotion • Warning signs during pregnancy (bleeding, vaginal liquids , respiratory distress, fever, abnominal pain, headache, seizures facial and hand eadema) • Promotion of 4 Antenatal Visits and follow on scheduled dates; • Appropriate follow-up on preventive treatment provided • Counselling on institutional birth and use of waiting house • Malaria Prevention and use of TIP and LLTN • STI/HIV and other transmitted infections ➢ Syphilis test and treatment ➢ HIV CT , partner and family involvement for appropriate PMTCT compliance and care ➢ Support for sero-discordant couples and Positive prevention, prevention of seroconversion during pregnancy ➢ Promotion of condom use • Prevention of Low Birth • TB prevention • Partum preparedness including plan for referral in case of emergency . (Family and community organization and preparation for emergency transportation) • Psychosocial support through Mother groups • Maternal deaths report (APE))		**Pregnancy Care** • Testo f proteinuria, blood surgar and urine II • Treatment of small and moderate complications: ➢ Moderate Anaemia ➢ Infections of genital, urinal, respiratory, gastric, etc. tract ➢ post-abortion care complications, referral whenever necessary ➢ Pré-Eclampsia • Treatment of any other moderate condition present • Treatment of pre-referral and reference of severe complications: Severe Preeclampsia, Eclâmpsia, Hemorrhage, Infections, post-abortion complications that required specialized attention, Premature ruptured membranes for more than 24 hours (Antibiotherapy and Prevention of Respiratory distress syndrom) **STI/HIV** • Treatment of all STI including the partner • Referral of failed cases to TARV **Prevention and management of other diseases** • Treatment of cases of moderate malaria and referral whenever necessary • Referral of cases of severe malaria • Test and Treatment of Tuberculosis	**Pregnancy Care:** • Complimentary exams of Diagnostic like Echography and others. • Management of all immunization • Management and treatment of moderated and severe complications: Anaemia, severe Preeclampsia, Eclampsia, Third trimester Bleeding (Placental abruption,placenta previa), Premature rupture of membranes (Preventive Treatment of respiratory Distress sindrome), Threat of premature birth, Ectopic Pregnancy, post abortion care • Management and treatment of other moderate and severe medical conditions and severe surgical conditions **STI/HIV** Management and treatment of stage III and IV of HIV **Prevention and Managment of other diseases** Management of extra-pulmonary TB Management of cases of resistant TB

Information, Education, Communication and Counseling:

- Counseling about danger signs (Bleeding, vaginal liquid discharge, Respiratory distress, Fever, Headache seizures, Abdominal Pains, seizures, Facial and hand

MATERNAL HEALTH	**CHILDBIRTH LABOR AND DELIVERY,IMEDIATE POST-PARTUM**	**Third Stage of Labor** • Recognition of labor and referral to the US; **Labor:** • Organize/Provide rapid transport to the Health facility for woman in labor and for the mother and the new-born; • In the case of impossible referral, or delays in arrival in the labor court: ➢ No execution of interventions or proceedings that could endanger the lives of the mother and/or the fetus; ➢ Perform Hygenic labor; **Immediate Post-Natal:** • Recognition of signs and symptoms of danger during childbirth and postnatal and send/refer to the Health facility; • Pay immediate attention to the newborn (Newborn IMCI package for basic care) ➢ Umbilical Cords care (don't apply any substances to the umbilical cord); ➢ Prevention of hypothermia through the method on Kangaroo mother (skin-to-skin contact with the mother) ➢ Discourage bathing within the first 6 hours ➢ Prevention of hypoglycemia through the promotion and support of exclusive and immediate breast feeding ➢ Recognition of signs of danger including signs of Neonatal Tetanus and forwarding to the Health facility • Promotion of hygienic care, personal and of the new-born	**Attention during third stage of labor and childbirth (COEmB):** • **Humanization of Labor (first stage)** ➢ Diagnostic of labour ➢ Assure measures of bio-safety ➢ Counselling and testing for HIV ➢ Counselling: feeding, deambultion, frequentemptying bladder, adopt most confortable position ➢ PMTCT Arv Prophylaxis ➢ Systematic use of partograph (opening at 4 cm and continuing) and attempted decision making in relation to labor procedure ➢ Screening and treatment/measures of support timely referral for: Premature rupture of membranes, premature labor, abnormal fetal lie, suspicion of fetal-pelvic incompatibility, preeclampsia/eclampsia, Prolonged labor or obstructed, signs of uterine pre-rupture, antenatal bleeding, and others. **Humanization of Labor** ➢ Permit more comfortable and convenient positions for the woman, depending on her choice ➢ Permit the presence of a companion depending on the woman's choice ➢ Timeous decision making in relation to the danger symptoms, signs and positions for the woman and fetus, as well as timeous referral of labor complications bleeding during birth, prolonged second stage of labor, bleeding and other situations) ➢ Active management of the third stage of labour (Oxitocin after delivery of placenta with controled traction and uterine massage) ➢ Protected ligation of umbilical cord (PMTCT) **Postnatal care** • Pay immediate attention to the newborn ➢ Prevention of hypothermia - immediate skin-to-skin contact with the mother ➢ Prevention of Hypoglycemia – breast feeding in the 1st hour after birth ➢ Detection of signs of danger to the newborn, measures of support and referrals • Monitoring and evaluation of the mother's condition (retained placenta lacerations and hemorrhages) ➢ Manual removal of placenta, if necessary ➢ Suturof first grade laceration, management of supportive care and referral of 2nd e 3rd grade laceration • Management, treatment/measures of support pre-referral and immediate referral of cases of postnatal moderate and severe bleeding **General Aspects:** • Promote the involvement of the father and the family, depending on the woman's choice, during the period of third phase of labor and childbirth.	**Attention during Labor** • **Humanization of Labor (second and third stage)** ➢ Management and treatment of mild to moderate complications during the period of dilatation third stage of labor – according to the national norms: ➢ Preeclampsia mild and severe ➢ Assisted delivery with vacuum extractor ➢ Premature ruptured membranes with the progress of labor • **Manage, treatment/measures of support pre-referral and timely referral of:** ➢ Threats of Preterm birth ➢ Preeclampsia mild and severe; and Eclampsia Premature rupture of membranes (without the progress of labor); ➢ Osbstructed labour; ➢ Manageable prolonged labor ; ➢ Prenatal bleeding and bleeding during birth; • Other medical or surgical situations/complications that require different attention. **Postnatal attention:** • Counseling, informed choice and insertion of DIU/implant • Treatment of mild to moderate complications during immediate postnatal stage (according to the norms of this level of attention): ➢ Suture of second grade of vaginal ➢ Mild and moderate postpatuum bleeding ➢ Pueperal infection ➢ Attention to newborn Read Attention to Newborn	**Attention during second and third stage of labor (COEmC):** • Induction of Labor; • Manage, treatment and follow up of moderate and severe complications according to the norms (including blood transfusion, Caesarian Section and hysterectomy): ➢ Early childbirth ➢ Severe Preeclampsia ➢ Eclâmpsia ➢ Premature Ruptured membranes ➢ Obstructured Labor ➢ Fetal bad presentations or abnormal lie position ➢ Antenatal Bleeding ➢ Bleeding during childbirth ➢ Other situations/complications medical and/or surgical that occur during the third stage of labor and childbirth; **Attention to Immediate Postnatal:** • Treatment of moderate to severe complications during immediate postnatal, according to the norms (including blood transfusion and hysterectomy): ➢ Moderate to severe Bleeding ➢ Infection/sépsis puérperal ➢ Suture of Third grade vaginal lacerations ➢ Other situations/complications medical and surgical that may occur during immediate postnatal;

MATERNAL HEALTH	**POSTNATAL ATTENTION AND FAMILY PLANNING**	**Postnatal:** • Support and Incentive for the presence at the consultation Postnatal during the 1st week (3rd and 7th day) after childbirth, or the earliest date after childbirth • Recognition of danger signs at the postnatal and immediate referral to the US • Promotion of hygienic care of the breasts **Family Planning:** • Counseling on planning of Pregnancies/FP, and for the utilization of a method of efficient FP (even during breast feeding) • Community leaders and community comites,males and women groups involvment to create demand increase adherence to modern methods, and aliminate resistance to modern methods **Nutrition and Vaccination:** • Vitamin A for the mother and the child after Child birth • Counseling, support and incentive for exclusive breast feeding • Counseling on educated nutrition –balanced diet for the mother **ITS/HIV and other diseases** • Recognition of signs and symptoms of STI and referral of the couple • Support for appropriate preventive and curative treatment • Counselling for appropriate use of condom for HIV/SIDA, and STI prevention • Participation in the support groups for HIV+ mothers **General Care:** • Counseling on the use of RMTI for pregnant women and children less than 5 years old • Encourage the communities in the heath activities participation(parades and woman and child weeks)	**CURING THE 1ST WEEK:** **1st Consultation PP/PF** **Information, Education e comunication** • Counselling on breastfeeeding earlier frequent nursing , latch on assistance prevention and relief of common difficulties, appropriate diet safe sex, and family planning, and warning folow up visits for both mother and baby. • Male envolviment **Gynecological Exam, screening, management, treatment or measures pre-referral and referral of** • Lacerations s, placenta retenction, infected episiectomy and other situations • Detect and manage/ measure/treatment pre-referral and timeous referral to women with signs and symptoms of infection/ puerperal sepsis **General Care** • Evaluation of the general state of the woman: complications on the breasts and with breast feeding, signs of anemia and other situations – treatment and referral if necessary • Identify and refer suspect post-natal depression cases **Provision of contraceptive chosen by the woman (according to the norms)** **Nutrition and Vaccination** • Supplementation with Iron, Folic Acid and Vitamin A • Nutritional counseling **STI/HIV** • CT of HIV (Refer to services for chronic diseases) • Counseling for ARV prophylasis for the mother and recent newborn (up to 4 weeks) • Follow-up after ARV prophylaxis • WHO staging and appropriate follow-up for pre ARV patients and if alegible referral for ART • Counseling **Family Planning Consultations** • Provision of contraceptive method chosen by the woman according to norms • Referral of women who choose tubal ligation • Safe Sex and use of Condom **Evaluation of the general state of the woman** • Detection, management of anemia and referral if necessary **Gynecological Examination** • Detection and treatment of infections and referral if necessary	**DURING 1ST WEEK:** **1st Consultation PP/FP:** **Gynecological Examination, screening, management, treatment or measures pre-referral and referral of:** • Women with moderate/severe signs of de infection/ puerperal sepsis **General Care/Consultations** • Evaluation of the general state of the woman: treatment of complications like anemia, infections puerperal sepsis (referral when necessary: severe cases) • Identify women with postnatal depression, perform initial management and referral **Nutrition and Vaccination** • Treat maternal Malnutrition **Family Planning** • Provision of contraceptive method chosen by the woman according to norms • Provision of IUDs and referral of women for tubal ligation up	**DURING THE 1ST WEEK:** **1st Consultation PP/PF:** • Treatment of all complications like severe anemia, bleeding, infection/ puerperal sepsis, severe postnatal depression • Counseling and provision of permanent contraception (Tubal ligation and vasectomy) **Post partum and family planning consultations** • Evaluation of the general state of the woman and treatment of all moderate to severe puerperal complications.

Area		Community Package	Minimum Package	Comprehensive Package	Specialized Package
NEWBORN'S HEALTH	IMMEDIATE ATTENTION ≤ 24 HOURS	**Counseling** • The Importance of the postnatal visit for the mother and newborn in the first week (3rd and 7th day), specially the earliest possible after birth • HIV testing • Consultation and treatment follow up (HIV+ mother and exposed infant) • Following immunization calendar (Pólio 0 and BCG) • Support and counseling for exclusive breastfeeding • Eraly birth registration • Promotion of use of local products to reinforce mother's diet • Hygenic care for the newborn **Implementation of Neonatal IMCI community package** • Identification of danger signs of newborn and timely • Advise on the use of treated mosquito bednets • Support consented defaulter tracking of children followed in at risk child consultation •Identification of newborns from	**Neonatal IMCI** • Basic neonatal care (umbilical cord care, prevention of hypothermia through immedate skin-to-skin contact with the mother, and of hypoglicemia through exclusive breastfeeding in the 1st hour after birth, vitamin K, ocular prophylaxis) • Assess signs of immediate risk and basic neonatal resuscitation. **General Care:** • Promote mother-infant staying in the same room at the health facility • Advice on good breastfeeding practices, 'pega' and position • Identification and referral of moderate / severe situations (preterm birth of <1500 g or 32 weeks of gestation, asphyxia, sepsis and convulsions) • Identification and reference of congenital malformations • Advice on home care, hygiene care in the management of newborns (including hand washing), and administration of oral treatment at home (eg ARV syrup, IHN) if necessary **STI/HIV** • Identification and referral of children born to non treated RPR+ mother; newborns of HIV+ mother; administration of ARV for PMTCT according to the guidelines • Referral of newborns of HIV+ mothers for follow up at Post Partum Consultation and at risk child consul from 4 weeks after birth • Counseling mother to get a PCR test for newborn at 4 weeks **Management of other diseases and situations:** • Identification and prophylaxis of newborns from TB+ mothers • Identification and referral of nweborns with jaundice, partum related trauma, congenital malformations and other risk situations	**Neonatal IMCI and CERN** • Basic neonatal resuscitation • Treatment and pre-referral measures of moderate to severe clinical conditions (including asphyxia, preterm birth <1500 g or 32 gstation weeks, Convulsions, Sepsis) and referral • Mother Canguru care in children >1500 g and referral if the newborn has complications • Treatment, pre-referral measures of sick newborn in need of specialuised care • Management of cases of moderate jaundice and pre-referral treatment of cases of jaundice • Management of minor/moderate partum trauma and referral of severe partum trauma cases **General care** • Identification of congenital malformation and referral **STI/HIV** • Management of congenital syphilis	**CERN and Management/treatment of all moderate to severe situations in the newborn** • Complete neonatal resuscitation • Management of prematurity and its complications • Management of severe partum related trauma • Management of pathologic jaundice and other severe complications • Management of congenital malformations • Management of severe asphyxia • Management of severe sepsis • Intensive neonatal care

	Attention to Newborn (24 hours to 28 days)	mothers with TB or HIV and referral to the health facility	**Neonatal IMCI:** • Assesment and follow up of the newborn (3rd, 7th and between 21st - 28th days) according to the guidelines and norms of post partum consultation and referral of all complications • Orientation on newborn care at home, identification of danger signs and management • Identification and treatment of localised infections according to neonatal IMCI • Identification of danger signs (malformations, jaundice, hypertonicity, umbilical cord, tense fontannelle, irritability...) and timely referral **Vacinations and General Care** • Vacination with BCG and Pólio • Counsel, promote and support exclusive breastfeding during the first 6 months of life (good practices, 'pega' and position), identify feeding problems, [provide counceling and support • Prevention of newborn hypothermia; Mother Canguru method • Advocacy for utilization of waiting houses in post-natal period for newborns with low weight • Promotion of adequate use of mosquito nets • Identification, prophylaxis, management and referral of risk situations/conditionsfor the newborn (ex: social problems,twins, formula feedingl, separated parents, orphans, exposition to TB and HIV, syphylis, etc) • Early birth registration **Management of Other Diseases or Situations:** • Recognition of signs of neonatal tetanus, pre-refrence measures and timely referral to specialised level	• Management of newborn complicated situations and referral of severe cases • Management of situations where the newborn is at risk	• Management of all newborn complications up to 28 days • Treatment of neonatal tetanus cases • Management of growth failure and eventual feeding problems and counselling

CHILD UNDER 5 YEARS OLD	**Community IMCI:** **Nutrition** • Counselling and support to exclusive breastfeeding during the first 6 months of life, good breast feeding practices, adequate complimentary feeding, continue breast feeding up to 24 months and balanced diet after weaning • Supplementation with Vitamin A (including cases of measles) • Deworming routine • Nutritional triage (MUAC): management, treatment and follow up of mild malnutrition without complications and referral of moderate, acute and severe malnutrition **Prevention and identification of Diseases:** • Counselling on: the adequate use of mosquito nets; the importance of the health card, the necessity of growth control and to complete the vaccine calendar; child care at home; and personal hygienic care, at home and in the community • Oral rehydration therapy • Treatment of diarhoeia with Zinc • Recognition of danger signs and referral to health facility • Identification, of signs and symptoms of Malaria and initiate the treatment (1st line) • Treatment of pneumonia (1st line) • Screening of TB contacts • Support consented tracking and follow up of cases in prophylaxis (CTX, INH, ARV) • Encourage communities to participate in activities (parades and woman and child week) • Information for prevention of accidents and intoxications. • Information and screening in oral, eye and skin problems • Identification and referral of children victims of domestic violence and sexual abuse • Community counseling and testing in health • Environment hygiene and sanitation	**IMCI** • Identification and treatment of diseases according to IMCI • Identification of danger signs (according to IMCI) and referral • Provider initiated counselling and testing – Evaluate signs of HIV infection and offer testing • Administration of better hydration salts and Zinc **General Care** • Perform complete physical exam including anthropometry, psychomotor development and referral in the presence of alert signs and development alterations • Identification of risky situations and referral to CCR (orphans, malnutrition, twins, exposure to HIV, exposure to TB…) • Rapid malaria test, Hbg with hemogloboral inmeter and BK collection • Basic packages of mobile brigades including interventions for child care • Prevention of accidents and intoxications • Distribution of mosquito nets and promotion of adequate use of nets and environment sanitation **Nutrition and Vaccination** • Advice and promote exclusive breastfeeding up to 6 months of age • Guide for adequate child alimentation and personal and oral hygiene • Promote vaccinations • Tetanus vaccination in the first and second classes (schools) • Deworming and vitamin A according to the calendar. **CCR** • Provider initiated counselling and testing for HIV (offer routine testing to all children and mothers with unknown serostatus) • Promotion of exclusive breastfeeding up to 6 months of age, counselling and nutritional follow up according to the national norms • Anthropometric assessment , psycomotoe development, identification of alert signs and referral • Screening of TB and referrral of TB suspect cases of contacts • Diagnostic of HIV in children born to HIV+ mothers according to the national protocol (Rapid HIV test and DBS for PCR where available) • CTX prophylaxis for children of HIV+ mothers • INH prophylaxis for children exposed to TB • Identification and management of cases of mild, moderate and severe malnourishment without complications, refer if the there is no improvement • Measures of pre-referral and referral for hospitalization of cases of acute and severe malnourishment with complications. • Identification and referral for cases of children in risky situations (ex: sexual abuse, domestic violence) for psycho-social support **Other transmittable diseases** • Identifications of rubella suspected cases • Identification and referral of TB suspected cases	**IMCI** • Management of cases of psyco-social disturbances • Treatment of diseases according to IMCI , identification of danger signs (according to IMCI) and treatment, referral of complicated cases • Management and referral of cases of alterations of development • Management of cases of meningitis according to the norms, including prophylaxis. **General Care** • Oxigen therapy • Clinical exams: Hemogram , Urin II, HTZ, Parasitology of feces, X-ray , LCR (Lab. With optic mycroscope), CD4 **Nutrition and Vaccination** • Treatment of child with severe malnourishment and complications; referral if it does not improve **HIV** • Follow up and ARV treatment for children infected with HIV • Referral in the case of therapeutic failure • CTX prophylaxis for children infected with HIV • Referral in case of Kaposi sarcoma diagnosis **CCR** • HIV diagnostic for children following the national guidelines (rapid test, BDS for PCR for children < 9 months exposed to HIV) • Identification of children infected with HIV and referral for clinical follow up according to the national guidelines. **Other transmittable diseases** • Management of cases of pulmonary tuberculosis and referral in cases of extra pulmonary tuberculosis	**Treatment of all complications and severe situations** • Complications of severe malaria, meningitis, malnutrition and measles. **General Care** • Neurologic and development consultation • Psychologic Consultation • Treatment of all surgical situations • Management of sexual abuse and domestic violece situations and referral to services of psyco-social support • Complimentary specialized analysis (laboratory,X-ray, TAC, RMM,Ecografia) **HIV** • Follow up of HIV infected children infected in second line therapeutic regimen • Follow up of HIV infected children by horizontal transmission • Follow up of children in treatment for Kaposi sarcoma **Other transmittable diseases** • Treatment of cases of complicated, resistant and extra- pulmonary tuberculosis